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THE MEDICAL JOURNAL OF AUSTRALIA

VOL. I.—30TH YEAR. SYDNEY, SATURDAY, JANUARY 23, 1943. No. 4.

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Table of Contents.

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ORIGINAL ARTICLES— Page.
Subacute and Chronic Meningococcal Septicæmia: A Review of Six Cases, by A. M. Hutson 67

REPORTS OF CASES—
Two Cases of Quinine Sensitivity, by W. M. Rose .. 71
Disease of the Coronary Artery, by A. W. Watkins, M.B., B.S. 71

REVIEWS—
Progress in Physical Therapy 72
Towards Total War 72
A Handbook of Medicine 72
Massage and Remedial Exercises 72
Cardiac Diseases 72

LEADING ARTICLES—
Congenital Cataract following German Measles in the Mother: An Adelaide Investigation 73

CURRENT COMMENT—
Head Injuries 74
Toxic Blood Level of Sulphanilamide from Local Application 75
Carcinoma of the Pancreas 75
Needles for the Withdrawal of Blood 75

ABSTRACTS FROM MEDICAL LITERATURE— Page.
Radiology 76
Physical Therapy 76

BRITISH MEDICAL ASSOCIATION NEWS—
Medico-Political 78
Notice 82

PUBLIC HEALTH—
Parliamentary Joint Committee on Social Security 83

OBITUARY—
George Henry Abbott 86
Paul Louis Florance 88

CORRESPONDENCE—
A Salaried Medical Service 88

NAVAL, MILITARY AND AIR FORCE—
Casualties 88
Decorations 88

MEDICAL APPOINTMENTS 88

BOOKS RECEIVED 89

DIARY FOR THE MONTH 88

MEDICAL APPOINTMENTS: IMPORTANT NOTICE .. 88

EDITORIAL NOTICES 88

SUPPLEMENT NUMBER 7 ON WAR MEDICINE AND SURGERY:
Treatment of Burns.

SUBACUTE AND CHRONIC MENINGOCOCCAL SEPTICÆMIA: A REVIEW OF SIX CASES.[1]

By A. M. HUTSON,
Major, Australian Army Medical Corps, Australian Imperial Force.

SINCE the outbreak of war we have all been concerned with the problem of meningococcal infection and with the danger that, at any time, an extensive epidemic may arise. Fortunately there has been no such epidemic, although there has been a significant increase in the number of cases. Accompanying this increased incidence of meningitis, there also has been an increase in other less obvious but equally interesting types of meningococcal infection. This group includes those cases in which the invading organism does not produce a meningitis, but manifests itself in a persistent low grade infection of the blood stream. These cases, occurring sporadically or in association with an epidemic, have been known for many years, but only recently have they received much attention in medical literature.

Recent work suggests that in common with many other infective organisms, the meningococcus primarily invades the blood stream before producing any localized lesion. Although it most commonly involves the meninges, it may invade the joints, and also give rise to "embolic" skin lesions.

The following forms of meningococcal infection may then be recognized: (*a*) an acute fulminant and rapidly fatal septicæmia, (*b*) initial septicæmia with intense meningitis, (*c*) moderate or mild meningitis with latent or masked septicæmia, (*d*) low grade septicæmia persisting as a subacute or chronic disease.

[1] Read at a meeting of the Royal Australasian College of Physicians, Sydney, on September 26, 1942.

Cutaneous lesions and arthritis may occur in each of these groups, but in the milder and more chronic infections of the fourth group these symptoms predominate in the clinical picture; and it is with this type that we are at present concerned.

Untreated, these cases of subacute or chronic meningococcal septicæmia may persist more or less indefinitely. Only occasionally do they lead to meningitis, but this did occur in one of the cases reported by Moss[1] after a febrile period of thirty-three days. In the six cases reported here, however, no sign of meningitis or meningeal irritation was detected at any stage; so that there was no indication to examine the cerebro-spinal fluid. Earlier reports describe cases in which pyrexia and other general symptoms continued for many months before terminating either fatally or in slow and tedious recovery. Since the introduction of the sulphonamide drugs, however, the outlook has changed dramatically. It has been shown that the meningococcus in the circulating blood is very susceptible to the action of the sulphonamides and that the disease can be promptly and easily cured.

Following a minor epidemic of cerebro-spinal meningitis in Western Australia in 1940, Moss[1] described a number of these cases and reviewed the available literature. His cases were seen during the course of the epidemic and he pointed out that they might be expected to appear whenever meningitis was prevalent in the community. He carefully outlined the clinical syndrome and emphasized the fact that the rash presented such specific features that it was usually possible to make a confident diagnosis at the first examination.

Soon after the publication of this paper by Moss, I had under my care a patient who presented all the features of the syndrome so clearly described by him; and since then I have seen in the Australian Military Forces a total of six soldiers suffering from this chronic septicæmic form of meningococcal infection. These cases are of great clinical

interest, not only on account of the comparative rarity of the condition, but also because they have all occurred sporadically in widely separated areas. Four were seen in an Australian general hospital in Palestine during the period June to September, 1941, and two in a casualty clearing station in northern New South Wales in August, 1942. In no case was there any known contact with other cases of meningococcal disease, nor was meningitis unduly prevalent in the area at the time. In contrast with the cases described by Moss, therefore, they did not occur during an epidemic and it is partly for this reason that they seem worthy of record.

In all of these cases, a clinical diagnosis was possible from the history of prolonged fever, arthropathies and very typical rash. In three the diagnosis was confirmed by the culture of *Neisseria meningitidis* from the blood, in another the organism could not be recovered, and in the remaining two the diagnosis was based on clinical grounds alone as laboratory facilities were not readily available.

The main features of the disease as it appeared in these patients were remarkably uniform and since the condition does not seem to be widely recognized, I venture to describe it again.

Clinical Features.

Mode of Onset.

The onset was fairly definite and marked by the occurrence of fever, tiredness and exhaustion, slight headache and general bodily aches and pains. The patient usually considered that the illness began with "sandfly fever" or "influenza" and the persistence of these general symptoms led, in one case, to the suspicion of enteric fever.

Fever.

The fever was irregular and prolonged—persisting in these cases for periods varying from ten days to ten weeks. Repeated attacks of slight shivering and sweating, either at night or in the early morning, were common, but definite rigors were not noted.

Two types of temperature chart may be described:

I. The irregular form with erratic fever lasting a day or so and followed by a relatively afebrile interval. Occasionally the fever is tertiary in type, suggesting the diagnosis of malaria, but the periodicity is by no means regular. In some cases the temperature is inverted, the daily maximum being reached with a sudden rise in the early morning. When this occurs, it may be regarded as a definite help in diagnosis.

II. The septicæmic type with a variable daily remittent fever reaching 102° to 104° F. It may be mentioned here that the patients tolerate the fever well, and may not look very ill despite a temperature recording of 103° F. Accompanying the fever and varying with it, were the general symptoms of exhaustion and fatigue, slight headache *et cetera*.

Joint Phenomena.

A prominent feature was the complaint of continued aching in the "muscles and sinews", together with definite pain in the back and in the joints. These joint pains were present in all cases, but were often transitory and varied from day to day. The pains spread slowly from joint to joint, involving mainly the distal portions of the limbs. Definite small effusions occurred, particularly in the ankle, knee and wrist joints. The swelling usually subsided rapidly, but often recurred in the same joint a day or two later. The fleeting and variable nature of the joint pains led to the initial diagnosis of rheumatic fever in some patients.

Cutaneous Lesions.

The most specific feature of this syndrome is the rash, and once seen it is easily recognized. The characteristic lesions are raised, rose pink or dusky red papules which occur scattered over the body and limbs. When these papules display a central petechial spot or linear hæmorrhage they may be regarded as diagnostic. The lesions are usually slightly raised, uniform in colour, and the colour fades evenly on firm pressure, returning when the pressure is released. If a central petechial spot is present, this does not fade. In size they vary from two or three millimetres to one or two centimetres across, and are usually circular or irregularly oval in shape.

Although the distribution may be uniform, they are commonly more profuse on the limbs and tend to occur particularly over the joints or bony prominences, for example, over the malleoli and bony points of the feet, on the borders of the tibiæ, over the dorsum of the hand and fingers, or about the radius and ulna near the wrist joint. When they occur over these bony points, on the sole of the foot, or overlying tendons, they are definitely tender on pressure, and are often associated with aching pain in the nearby joint.

The number of lesions varies considerably; there may be only six or eight discrete papules, or they may be profuse, numbering fifty or more on each limb. Many are not very prominent on casual inspection, but a definite search usually reveals many more than were suspected. When small, they may be overlooked, or mistaken for insect bites, urticarial wheals *et cetera*. A few isolated petechial spots may also be present.

The papules appear in definite crops and each lesion may last two or three days, slowly fading and leaving a faint brown stain. Occasionally several generations may coexist, new lesions appearing with each relapse of fever.

It may be noted that the rash differs considerably from the classical purpura associated with fulminant meningitis.

Unusual Forms.—Apart from the vivid macules and papules described above, other larger lesions may appear. There may be painful nodes resembling *erythema nodosum* on a small scale, or larger erythematous and œdematous patches, not unlike small areas of cellulitis. A case in which lesions of this type were present was recently described by Driver.[2]

It may be assumed that the nodes and papules result from the arrest of small coccal emboli in the cutaneous vessels. Kennedy[1] succeeded in isolating the meningococcus from the tissue fluid of a roseolar papule.

General Features.

Apart from the headache, there was no evidence of meningeal irritation in any of these patients and therefore the cerebro-spinal fluid was not examined. Blood examination usually revealed a slight polymorphonuclear leucocytosis. Occasionally the spleen is palpable.

Treatment.

The response to sulphonamide is dramatic and carries almost specific diagnostic value. Sulphapyridine was used in this series, and in every case the temperature subsided immediately. The cutaneous lesions fade very quickly—there is usually a discernible difference in their appearance within twenty-four hours—and all trace, except faint residual staining, has usually gone within two or three days.

The arthritic pains and joint swellings subside rapidly, and within twenty-four hours the patient usually feels well and on the way to recovery.

Relatively small doses of sulphapyridine are sufficient to effect a cure. The routine course was to give an initial dose of two or three grammes, followed by one gramme every four hours until a total of approximately thirty grammes had been given.

Since the sulphonamides are used so universally, it is undoubted that some patients must have been treated empirically and recovered; but in a condition so interesting and instructive as this, it is surely worth while to make an accurate diagnosis whenever this is possible.

Case Records.

Three representative case records are presented in detail, and they illustrate the general features of the disease as it was seen in this series. The histories of the other three patients were similar in every respect.

Case I.

This patient, a soldier, aged twenty-one years, was admitted to an Australian general hospital in Palestine on June 7, 1941.

In January, 1941, he suffered a shrapnel wound in the left leg, which healed readily, but he had not felt really well since. He stated that he had been ill for at least two months, complaining of general malaise, frequent headaches and attacks of fever and sweating each night. For two weeks he had moderately severe backache, and frequent aching pain in the legs and knees. The headache and fever continued, and he was sent to hospital for investigation because he had been in close contact with a patient suffering from enteric fever.

On admission to hospital his temperature was 100° F. and he complained of pain in the left ankle. On examination, the medical officer noted that there were numerous papules on the body and limbs resembling insect bites. There were some rhonchi present at the base of the left lung, but no other definite findings. It was assumed that he was suffering from typhoid fever and specimens of blood and fæces were sent to the laboratory for examination. He continued to run an irregular temperature (Figure I) and on June 12 the spleen was just palpable. He complained of frequent sweating and of pain in both ankles.

Examination of blood films revealed no malaria parasites, and the cultures made from the blood and the fæces contained no typhoid bacilli. Agglutination tests for typhoid showed agglutination only in titres that would be expected after inoculation with "T.A.B." vaccine (H agglutinogens, 1 in 320; O agglutinogens, 1 in 160). A leucocyte count revealed 9,000 cells per cubic millimetre, 70% of the cells being polymorphonuclear. A skiagram of the chest revealed no abnormality.

I first saw the patient on June 16 and two days later realized that the lesions originally thought to be insect bites presented specific and unusual features. There were deep-red macules and papules scattered on both the body and limbs. The lesions varied in size from that of a pin's head to one or two centimetres in diameter, were slightly raised and faded on pressure. They were present particularly about the bony points of the feet, about the wrist joints and on the dorsum of the left fourth and fifth fingers, and in these sites they were definitely tender. Other papules were scattered on the body and back, and were numerous in the axillæ. One red œdematous nodule was prominent on the left orbital margin and displayed a central petechial hæmorrhage. Meningococcal septicæmia was suspected as the rash so closely resembled that described by Moss.

On June 19, specimens of blood were taken and inoculated into tryptic broth. A naso-pharyngeal swab was also made and sent for examination. The spleen was still palpable and there was now a small effusion into the left knee joint.

On the next day the temperature did not rise above 99° F., but on June 21 another specimen of blood was taken while the temperature was 102·2° F. An attempt was also made to aspirate a little tissue fluid from one of the roseolar papules for culture. On this day the left knee had returned to normal and a small effusion appeared in the right knee joint. The rash was still present and it was decided to begin treatment without waiting for the results of the cultural investigations.

Sulphapyridine was used and six grammes were given daily for five days, and then the dose was reduced to three grammes daily until a total of thirty-six grammes had been given. The response was immediate, the temperature subsiding and remaining normal after the first day. The rash, joint swellings and pain disappeared quickly and did not recur. After an illness lasting at least ten weeks the patient was well and ready for discharge from hospital within ten days.

Unfortunately no growth could be demonstrated in the blood-inoculated media, nor were meningococci found in the throat swab or in the fluid from the skin papule. Possibly the tryptic broth and serum broth used on this occasion were not suitable media, and for the next case it was decided to use glucose citrate broth.

Despite this failure to recover the organism, the clinical features and rapid therapeutic response justified a clinical diagnosis of meningococcal septicæmia. This assumption seemed reasonable when, in the next three similar cases, including Case II reported in detail here, the meningococcus was isolated and identified, glucose citrate broth being used as the culture medium.

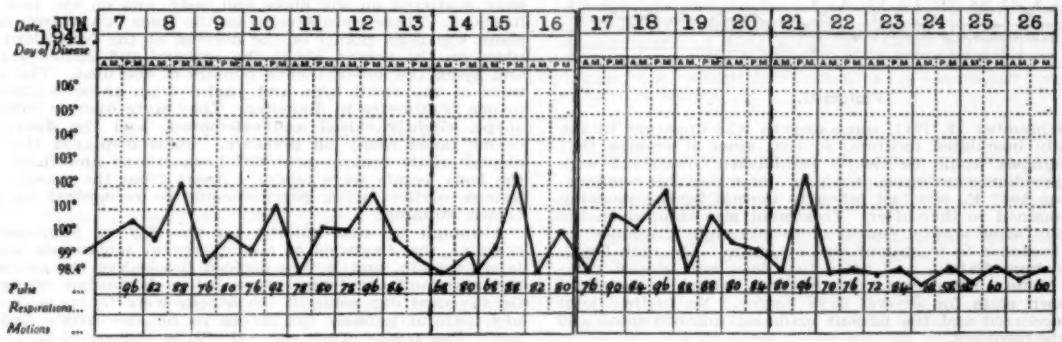

FIGURE I.

Case II.

The second case was that of a soldier, aged twenty-seven years, who was admitted to hospital on September 14, 1941.

He stated that his illness had begun fourteen days before, when he woke with a slight fever, headache and general malaise and thought that he was suffering from sandfly fever. He felt better for two or three days and then the fever and its accompanying general symptoms recurred. This sequence was repeated three times and on his admission to hospital his temperature was 100·6° F.

On examination the only positive finding was a red, slightly tender swelling on the inner side of the right calf. This patch was of a dull red colour about five centimetres long and resembled a small area of cellulitis. His throat was clean, the heart and lungs were normal and the spleen was not palpable. There was no meningismus.

On the evening of September 15, 1941, the temperature was 103° F. and he complained of pain and swelling in the right knee. The knee was found to be tender and slightly swollen. At the same time the characteristic rash was observed. There were scattered vivid pink macules and papules on the legs, particularly prominent on the dorsum of the feet, about the ankle joints and over the tibiæ. Altogether there were about thirty spots on each leg, each lesion fading evenly on pressure and rapidly returning on the release of pressure. Those over the malleoli and bony prominences were definitely tender. The spots varied in size from one-half to one centimetre; most were rounded, others irregular or oval in shape. There were a few similar lesions on the trunk, chest and abdomen, and several smaller red macules on each forearm, particularly along the radial border near the wrist joint.

On September 16, 1941, the rash was still present, a few new lesions had appeared, and in the evening the temperature again rose to 103° F. A clinical diagnosis of meningococcal septicæmia seemed justified and specimens of blood were taken for examination by culture methods on September 17, 1941.

It was decided to observe the course of the fever before beginning treatment, and as shown on the chart (Figure II) the temperature was elevated to 103° or 104° F. each evening. During the day he was relatively comfortable, the temperature rising suddenly at about 4 p.m. and remaining high only for a few hours. At no stage did he look very ill despite the fever. On September 18, 1941, the right ankle became painful and swollen and the rash was a little more vivid. On the inner border of the right foot he developed a red papular swelling about eight centimetres long, closely resembling a large urticarial wheal, with, in the centre, several petechial linear hæmorrhages. Small petechial spots also appeared in the centre of several of the original smaller lesions.

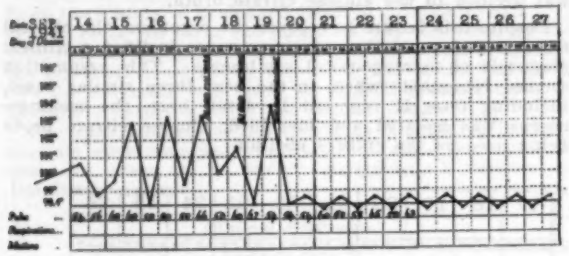

FIGURE II.

On September 19, 1941, some growth was apparent in the originally inoculated medium, so that since it seemed that the diagnosis would be clearly established, treatment with sulphapyridine was begun at 2 p.m. At 6 p.m. his temperature was 104° F., but had fallen to normal by the morning and remained so thereafter. Treatment was stopped on the sixth day after a total course of twenty-eight grammes.

The response to treatment was dramatic. The rash began to fade immediately, and after two days had almost completely gone. Some spots disappeared; others left a slight red-brown stain for several days longer. No further joint pains occurred and the patient made an uninterrupted and complete recovery.

Report on the Blood Cultures.—Blood was taken on September 17 and September 18, 1941, and inoculated into glucose citrate broth. From both tubes a growth was obtained of Gram-negative diplococci, morphologically and culturally resembling *Neisseria meningitidis*. The organism proved viable on subculture, and after some difficulty a suspension of the growth was agglutinated, in a dilution of 1 in 1,280, by an antiserum of the meningococcus Type I.

The relapsing type of fever continued (Figure III), associated with general aches and pains. During the next few days the ankles became swollen alternately several times, each time the swelling lasting for a day or so. The knees remained painful, but not swollen.

At this stage he first noted the rash, stating that painful red spots appeared on the feet and legs, and that others were scattered over the body and face. He noted that they came in crops and faded every two or three days.

On August 11 the temperature rose to 103·6° F. and he was admitted to a main dressing station. He remained there for eight days and during this time his temperature was still elevated and irregular. He complained persistently of backache, of aching in the joints and occasionally of headache. There was some transient swelling of the knee joints, but no other positive clinical findings, except the tender papules on the legs. A diagnosis of rheumatic fever was suggested and he was given full doses of salicylates without relief.

On August 20 he was transferred to a casualty clearing station with a diagnosis of diffuse fibrositis.

At this stage he looked toxic and ill, but not seriously so. General examination revealed some painful swelling of the ankle and wrist joints, but no other abnormality apart from the profuse rash. Numerous red maculo-papular lesions were scattered on the limbs and body, and on the face and forehead. There were several on the soles of the feet, many about the bony points of the dorsum of the feet, along the tibiæ, on the thighs, about the axillary and deltoid regions and along the subcutaneous borders of the ulna. The spots were of the small type and varied from three millimetres to one centimetre in diameter. They were oval or round in shape, slightly raised and œdematous and the dusky red colour faded easily on pressure. Some displayed the very characteristic central petechial hæmorrhage and those over the bony points were tender. Apart from the recent vivid lesions, earlier fading papules could be recognized by faint brown staining.

Although he was afebrile on the day of admission to hospital, the diagnosis of meningococcal septicæmia seemed fairly certain, and it was decided to observe the course of the rash and the temperature before beginning treatment. On the next day some of the lesions were fading and other new painful papules had appeared on the wrists and the feet. The temperature was 101° F. in the morning.

On August 22 the rash was more vivid, he complained of severe pain in several joints and the temperature rose to 102·6° F. in the morning. Since there were no facilities for examination of the blood by culture methods, this relapse of fever with inverted temperature seemed sufficient evidence to confirm the diagnosis, and treatment was begun.

After twenty-four hours' treatment with routine doses of sulphapyridine, all the papules had faded and those which

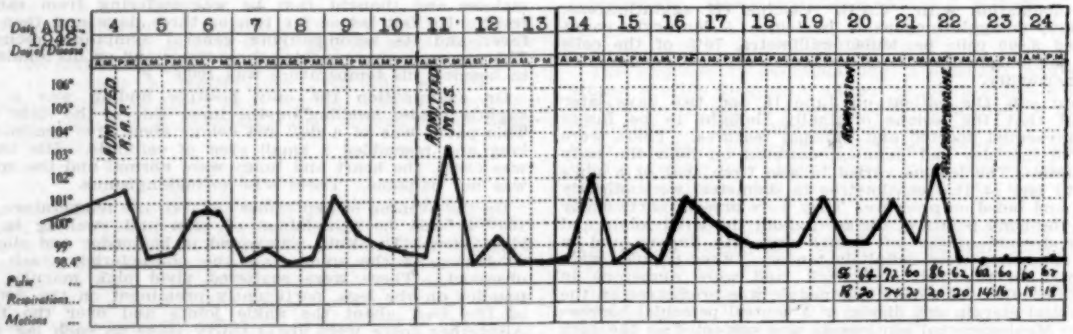

FIGURE III.

Case III.

This patient, a previously healthy soldier, aged twenty-five years, was first seen on August 20, 1942. He stated that his illness had begun twenty-eight days before, when he noted feverishness, headache, occasional dizziness, tired aching legs, and "stiffness in the muscles and sinews". These symptoms continued for eight days and then he reported ill and was admitted to the regimental aid post on August 4, 1942. His temperature was then 101·5° F. On the following morning he complained of pain in the knees and ankles, and said that they felt stiff.

had been tender were much less so. He felt very well, the joint pains disappeared and the temperature remained normal. After completing the course of sulphapyridine—a total of thirty grammes—the patient made a rapid and complete recovery.

Summary.

1. Six cases of chronic meningococcal septicæmia are reported. These all occurred sporadically, four amongst Australian troops in Palestine and two in New South Wales. They were not associated with any local epidemic of meningitis.

2. The clinical features are described with special reference to the prolonged relapsing fever, arthropathy and characteristic skin lesions. These features are so specific that a clinical diagnosis can be made with confidence. The diagnosis can often be confirmed when culture methods are applied to the blood.

3. Treatment with sulphapyridine is curative.

Acknowledgements.

I should like to express my thanks to Major-General S. R. Burston, C.B., C.B.E., D.S.O., V.D., Director-General of Medical Services, for permission to report these cases, and to Major C. Backhouse for his excellent work in the laboratory.

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(2) A. A. Driver: "Chronic Meningococcal Septicæmia", *British Medical Journal*, Volume I, 1942, page 695.

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Reports of Cases.

TWO CASES OF QUININE SENSITIVITY.

By W. M. ROSE,
Captain, Australian Army Medical Corps.

TROOPS serving in malarious areas are given quinine as a routine suppressive measure, and cases of sensitivity to the drug appear to be quite rare. In recent weeks two interesting cases of quinine sensitivity have passed through the hospital to which I am attached, and it is felt that their recording may be of interest and value not only to those who practise medicine in tropical areas. The form of quinine used as a routine suppressive measure in this zone is the bisulphate, and the dose varies from five to ten grains, depending upon the malarial incidence in the area of service.

Case I.

Private K. was admitted to hospital with a generalized erythematous eruption, confined to the trunk and proximal portions of the extremities. His temperature was 99·6° F., and he complained of a swollen penis and pain on micturition. He gave the history that he had been in the area for ten days, and that in this time he had taken quinine each night. After the first dose he had noticed some burning in his penis on micturition, which soon became a more or less constant discomfort, and the penis had become swollen. The rash had appeared only forty-eight hours prior to his admission to hospital. He further volunteered the information that his penis had become swollen in a similar manner after his wife had used a pessary as a contraceptive. At that time a medical man had told him the pessary might be the cause of the trouble, which cleared up rapidly.

Once the patient was in hospital, the ingestion of quinine was stopped, and all his discomfort had gone within forty-eight hours. The erythema faded gradually, and later an extensive exfoliation of the skin occurred, especially on the palms and soles. A moistened tablet of quinine bisulphate was applied to abrasions of the skin over the scapular area, and plain strapping was used as a control. After twenty-four hours a very marked area of erythema was present around the tablet, while the control area was normal in appearance.

Case II.

Private F. was admitted to hospital within a week of his arrival in the area. He said that two years previously his penis had become swollen after his wife had used contraceptives, and the family doctor had said that he must be sensitive to the preparation used. Since his arrival he had taken only two tablets of quinine. Within an hour he had an urgent desire for micturition and a burning sensation in his penis, although he was unable to pass urine at the time. Some four hours later he noticed a burning sensation all over the body, and a great itching of the skin. The following morning the foreskin and scrotum were much swollen.

While under observation in hospital, this man was given a five-grain dose of quinine bisulphate. The reaction was obvious in about six hours, and was similar to that described; in addition, a swelling of the nasal mucosa with some blockage of the airway was observed. All symptoms disappeared within twenty minutes when the patient was given a hypodermic injection of ten minims of a 1:1,000 solution of adrenaline by Hirst's method. The later intradermal injection of five minims of a 1% solution of quinine dihydrochloride in sterile water caused a red wheal, which was at its maximum within twenty minutes and then faded slowly. A control injection of the same sterile water produced no reaction.

Discussion.

These two cases are of interest mainly because they illustrate a local sensitization to quinine. Neither man had been in the tropics previously, nor could either recall having taken quinine orally, although that is of no significance, since quinine is present in many so-called "tonics". However, each man gave a history of a well-defined local reaction following the use of contraceptive pessaries by his wife, and many of these pessaries contain quinine. On his coming into contact with the drug again, the penis was the first part to be affected. Neither of these men had had an attack of malaria, but "Atebrin" was used as a suppressive measure without ill effects.

Summary.

1. Two cases of sensitivity to quinine are presented.

2. Each subject showed a local sensitization to the drug, apparently following the use by his wife of contraceptive pessaries containing quinine.

3. "Atebrin" appears to be a suitable substitute for quinine as a suppressive measure in such cases.

Acknowledgements.

I should like to express my thanks to Colonel N. H. Fairley for his interest in these cases and his suggestion that they should be published, and also to the commanding officer of this unit for permission to present them, and to my colleagues for their interest and suggestions.

DISEASE OF THE CORONARY ARTERY.

By A. W. WATKINS, M.B., B.S.,
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I RECEIVED an urgent summons to A.B., a male, aged fifty years, who had suddenly collapsed whilst speaking at the telephone. On my arrival he was lying on the floor quite dead. He was in his pyjamas and there was clear frothy mucus literally pouring from both nostrils and mouth and the conjunctivæ were œdematous. His pyjama coat was saturated in the front with this mucous fluid and the face and upper part of the neck were stained an intense lilac colour.

This man had played two sets of tennis only the afternoon before and had not consulted a doctor for many years, as his health had not caused him any concern. The post-mortem examination disclosed that the heart weighed 24 ounces; there was cheesy material in both branches of the left coronary artery and about one inch from the commencement of the right a length of one inch was quite blocked and much fibroid change was present in the apex of the left ventricle. In addition the lungs showed great œdema and abundant froth in the air passages, the stomach containing much frothy mucus; the spleen was adherent and the kidneys showed interstitial changes.

The case was interesting, I thought, by clearly demonstrating that comparatively good health can be enjoyed with advanced coronary disease. It also shows with the gradual narrowing of these arteries how extraordinary is the amount of œdema and how catastrophic is the result when an occlusion does occur.

Reviews.

PROGRESS IN PHYSICAL THERAPY.

PHYSICAL THERAPY, one of the oldest forms of medical treatment, is needed today almost more than ever. In regard to every subject in the medical curriculum the statement is made at some time or other that not sufficient time is given to its study. While such a statement would not be true of all subjects, it would almost certainly be true of physical therapy. Those who do study the subject know its value; those who do not, should certainly make an effort to repair the omission. Both groups of practitioners will be well advised to study the "Year Book of Physical Therapy". The volume for 1942 has been published[1] and will be a useful addition to any practitioner's library—not to be looked at but to be studied.

The editor of this book, Dr. Richard Kovács, has divided it into two main parts, the first part dealing with physical therapy methods and the second with applied physical therapy. The plan usually adopted by "Year Book" publications has been followed—worthwhile articles are abstracted and occasionally a footnote is appended by the editor. In the first part of the work the methods considered comprise thermotherapy, electrotherapy, light therapy, hydrotherapy, climatotherapy, mechanotherapy, physical education and rehabilitation, occupational therapy and institutional work. Radiotherapy is not included; the subject of radiotherapeutics occupies the second half of the Year Book on radiology and this is perhaps the most suitable arrangement.

The editor in his planning of the first part of this book has wisely included in the first part of each subdivision a small section on the theoretical side. Thus the first group of papers under the heading of thermotherapy deals with physiology; under electrotherapy we find electrophysics; under light therapy, physiology and pathology and so on. Under the section of climatotherapy a page-long abstract of the article by C. E. Corlette on the measurement of the drying capacity of wind is given. The section on physical education and rehabilitation is short, but full of interest. The editor precedes the abstracts in this section with a note in which he insists that health guidance and physical training should be systematic and authoritative.

The first section in the second part of the book (applied physical therapy) deals with physical therapy in war. One of the chief articles here is concerned with the rehabilitation of injured air crews. There is no need to enumerate the several sections; one of the most important is that on traumatic conditions. Several abstracts of articles on the Kenny treatment of poliomyelitis are included, and the editor precedes these with an abstract from an editorial in *The Journal of the American Medical Association* in which it is insisted that there is no experimental evidence to support the contention that single muscle units may as a result of appropriate manipulation be encouraged to send their nerve fibres to muscle fibres rendered atrophic by anterior horn degeneration. Sections are devoted to pædiatrics, orthopædics, gynæcological conditions, genito-urinary conditions, mental conditions and those of the eye, ear, nose and throat.

This book is one that should be in the hands of all who include physical therapy in their treatment of sick people. The index is satisfactory and is in two parts—subjects and authors.

TOWARDS TOTAL WAR.

IN his book "Towards Total War", Professor Copland offers us his picture of a total war effort, and attempts to define what it really means.[2] He divides the development of a total war effort into three stages, the first being the stage in which we absorb unemployed and idle resources, the second involving the transfer of resources from civilian needs to war needs, and the third when transfers are completed and the war economy is stabilized.

Professor Copland reasons convincingly, but a number of thoughtful readers will disagree with his statements that in peace time it does not matter very much if private industry wastes resources as a result of wrong decisions, and that it is a hindrance to the war effort to discuss whether changes in the order of economic society are to be permanent. Just as we must organize our economy in an impartial manner to obtain a total war effort, so we must organize and plan for peace. From both we should gain a greater understanding of one another. And an impartial and efficient control into the days of peace that would secure a standard of living essential for the health and happiness of the people, is preferable to a "return to our usual freedom of action", whatever that means.

The book should be read by all who wish to follow and understand the steps that are being taken to organize the population and materials of Australia for a total war effort.

A HANDBOOK OF MEDICINE.

G. F. WALKER has produced a useful handbook of medicine for final year students.[1] As a matter of fact he states in the preface that the work is intended for final year students and for practitioners doing hospital work. The subject matter is arranged according to systems and further subdivisions are an aid to clarity. The material is condensed, but not to the unpleasant degree of certain volumes of the cram-book type—the bread and butter essentials of clinical medicine are boldly and clearly stated, together with sufficient theoretical detail to serve as an explanation and to guide the reader into the right channels for further knowledge. The book is a useful bridge between a text-book and one devoted to physical signs.

MASSAGE AND REMEDIAL EXERCISES.

IN the fifth edition of "Massage and Remedial Exercises in Medical and Surgical Conditions", Noel M. Tidy deals with two subjects—burns and amputation stumps—not previously included.[3] The latter subject is very important, as the proper handling of the stump during the healing process frequently reduces the time between the operation and the successful fitting of the artificial limb. The short chapter on this subject is full of useful information.

This edition otherwise is practically identical with the fourth edition. It contains a lot of information of value to the surgeon as well as to the masseuse. It is recommended to be read by the latter as giving a very comprehensive review of the details of treatment from the point of view of the physiotherapist and also by the surgeon who wishes to know how to supervise all varieties of treatment.

The exercises are well illustrated and clearly described.

CARDIAC DISEASES.

THE third edition of "Diseases of the Heart",[2] by Sir Thomas Lewis, has been very slightly altered; apparently the author does not consider that students and practitioners need any more detailed discussion. The main addition is a more complete review of pericarditis with a clear separation of constrictive pericarditis as a definite clinical condition, which is an improvement; but the chapter is still one of the least satisfactory in the book.

It is disappointing to find very little change in the treatment of the "effort syndrome", which is still discussed as though it had an organic basis; at the same time there is a rather grudging acceptance of anxiety neurosis as a cause. Observations in the present war seem to make it clearer than ever that the condition is merely a neurosis due to fear and not an evidence of neuro-circulatory weakness and will disappear when this fact is grasped by the profession.

The book is still an admirable text-book for students and practitioners.

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[1] "The 1942 Year Book of Physical Therapy", edited by Richard Kovács, M.D.; 1942. Chicago: The Yearbook Publishers. 7¼" × 5", pp. 416, with illustrations. Price: $3.00.

[2] "Towards Total War", by Professor D. B. Copland; 1942. Sydney: Angus and Robertson Limited. 7¼" × 5", pp. 46, with charts. Price: 2s.

[1] "Handbook of Medicine for Final Year Students", by G. F. Walker, M.D. (Leeds), M.R.C.P. (London); Second Edition; 1942. London: Sylviro Publications Limited. Crown 8vo, pp. 320.

[3] "Massage and Remedial Exercises in Medical and Surgical Conditions", by N. M. Tidy; Fifth Edition; 1941. Bristol: John Wright and Sons Limited. Demy 8vo, pp. 475, with illustrations. Price: 17s. 6d. net.

[2] "Diseases of the Heart Described for Practitioners and Students", by Sir Thomas Lewis, C.B.E., F.R.S., M.D., D.Sc., LL.D., F.R.C.P.; Third Edition; 1942. London: Macmillan and Company, Limited. Medium 8vo, pp. 320, with 45 illustrations. Price: 15s. net.

The Medical Journal of Australia

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All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

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CONGENITAL CATARACT FOLLOWING GERMAN MEASLES IN THE MOTHER: AN ADELAIDE INVESTIGATION.

IN December, 1941, reference was made in these columns to a remarkable series of cases reported by Dr. N. M. Gregg, of Sydney, at the annual meeting of the Ophthalmological Society of Australia (British Medical Association) in October of that year. This was a series in which congenital cataract occurred in babies whose mothers had suffered during the early stages of pregnancy or just before pregnancy from an illness that was diagnosed as German measles. The babies affected were of small size and ill-nourished; they were generally difficult to feed and for this reason were often taken to the pædiatrician before they were considered to be well enough to be placed under the care of the honorary ophthalmic surgeon. (The children were seen at the Royal Alexandra Hospital for Children, Sydney.) The cataracts were generally, but not always, bilateral and had almost invariably been present since birth as dense white opacities completely occupying the pupillary area. The discovery of this unusual sequence—an illness like German measles in the mother and cataract in the child—naturally aroused Dr. Gregg's spirit of inquiry and he set to work to discover whether any of his brother ophthalmologists had come across cases of a similar kind. The series of 78 cases collected in this way is most remarkable and at the time when they were first described gave rise to much comment and speculation. Readers should perhaps be reminded that in Dr. Gregg's opinion the appearance of the cataract did not correspond to any of the morphological types of congenital and developmental lenticular opacities which have been reported. He described it as being subtotal. Two further points are to be noted. In the first place in 16 of the 78 cases the cataract was unilateral and in 11 of the 16 monocular cases the affected eye was smaller than the other. The second point is that in a large proportion of cases a congenital defect of the heart was present. The clinical signs were described as "suggesting the continuance of a fœtal condition or a malformation of the heart". This is a short account of the original cases described by Dr. Gregg. But to describe a condition and to determine its causation are two very different tasks. Dr. Gregg, as we pointed out in December, 1941, did not entirely commit himself to the cause and effect view of this sequence. His words may be quoted again:

> If we allow the possibility of the lens being affected by infective processes in the mother, and if we find the same infection occurring at approximately the same period early in the pregnancy in almost all the cases, and if we then find that the babies of these mothers have cataracts of a more or less uniform type which involve the fibres found at that period, then I think it is reasonable to assume that it cannot be a mere coincidence, but that there must be some definite connexion between that infection and the morbid condition of the lens.

It should also be remembered that Dr. Gregg made what we termed the entirely reasonable suggestion that some of the rashes diagnosed as due to German measles were occasioned by a toxic erythema from one or other of the severe throat infections which had been prevalent in 1940 at the time when the epidemic of German measles occurred.

During the last two years little has been heard about this peculiar sequence. Few if any new cases have been recorded in Sydney, but some cases have been reported in Adelaide, and in that city a plan of inquiry has been drafted and action is already being taken. The South Australian Branch of the British Medical Association has sent to each member of the Branch a circular letter signed by Dr. R. J. Verco, the President, and Professor E. Weston Hurst, Director of the Institute of Medical and Veterinary Science, Adelaide. In this circular the facts of Dr. Gregg's original observations are set out and it is stated that since October, 1941, the prevalence of rubella has continued, that cases of congenital cataract are still occurring and that a number have been encountered in South Australia. The investigation into the occurrence of rubella and rubella-like infections is planned to cover three groups of cases. The first comprises cases in which a child has been born with serious congenital defect. To cover these cases a *questionnaire* has been issued for completion by the medical attendant and it is proposed that, if possible, the child shall be examined by one or more of the group of specialists collaborating in the inquiry. The second group includes cases in which a healthy child has been born of a mother who suffered from an acute exanthem during her pregnancy; for this group the same *questionnaire* as for the previous group will be used. The third group comprises cases in which a pregnant woman develops German measles or true measles. In regard to the last group the procedure to be adopted varies according to whether the patient lives in the metropolitan area or in the country. In the former circumstances it is suggested that Dr. Charles Swan, of the Institute of Medical and Veterinary Science, shall be given permission to interview the patient as soon as a diagnosis is made and to follow the history of the child after birth. If the patient lives in the country it is hoped that the data asked for in the *questionnaire* will be supplied, whether the child is born

healthy or not. This is an admirable plan of action and has the virtue of placing almost all the work in the hands of one observer. Further, as Dr. Swan is working under the ægis of the National Health and Medical Research Council, this body is alive to the importance of the subject.

The plans for the investigation in Adelaide cover South Australia only, but this matter affects the whole Commonwealth and some arrangement will have to be made for the collection of material in the other States. These States will have to be content with a plan less satisfactory than that operating in Adelaide. What is urgently needed is that some unanimous opinion shall be formed regarding the condition from which the mother suffers in these cases. To this end it would be desirable that as many patients as possible who are suffering from German measles or a similar complaint should be examined by one competent observer and that a complete history should be taken. This history should be kept in such a way that it would be available if the patient concerned subsequently became pregnant. Failing such a more or less complete arrangement, special attention might be paid to the subject in the ante-natal clinic of every obstetric and general hospital. In these clinics special inquiry should be made about the appearance, duration, severity and so on of any exanthem and a detailed statement made and included in the history, which should be readily available for future reference. If any cases were discovered in which an exanthem was present just before pregnancy occurred, or if an exanthem appeared in a patient already pregnant, the affected patients should be grouped together and placed for continuous and detailed observation under one medical officer.

As the South Australian investigation, which is really an important step in preventive medicine, proceeds along its well-planned course we may be certain that the practitioners in the State will give full cooperation. In other States some one must prevail first of all on the ante-natal clinic staffs and ultimately on all general practitioners to interest themselves in this subject. Since the original observations came from the Ophthalmological Society of Australia, it might well do the preliminary urging.

Current Comment.

HEAD INJURIES.

In the ten years that have passed since the subject of head injuries was succinctly reviewed by V. M. Coppleson[1] progress in our knowledge of it has been slow and has been partly concerned with an appreciation of the changes that occur in the intracranial pressure. In this connexion M. A. Glaser[2] has proposed that head injuries be classified on the basis of the state of the intracranial pressure, for he states that by such a classification more accurate diagnoses can be made, and the regimen of treatment may be more scientifically carried out; moreover it would be possible to differentiate readily the surgical from the non-surgical case and to outline more accurately the therapy for each group. Such a classification is valuable, for it directs attention to the fact that the intracranial pressure is not invariably raised after a head injury. We have, as Glaser points out, long assumed that after a head injury variations of pulse rate, blood pressure, respiration, pulse pressure and temperature are diagnostic of increased intracranial pressure. That this is fallacious has been shown by spinal manometric readings; and consequently, to dehydrate every patient with a head injury indiscriminately is without a scientific basis. On the other had extensive damage to the brain will cause death, and in such a case, even though the intracranial pressure is found to be elevated, the removal of a large blood clot will not always save the patient's life.

There has been a tendency to neglect the fact that immediately after a severe head injury the patient is usually in a state of shock and that during this time rest, warmth and other anti-shock measures are indicated rather than active interference. There has been much discussion as to the indications for lumbar puncture in these cases; some surgeons prefer to perform lumbar puncture in all their cases of head injuries. However, it is certain that this measure is contraindicated during the initial stage of shock. Glaser makes the suggestion that if the patient is not responding satisfactorily, as indicated by increasing coma or paralysis as well as by marked variation in the pulse and blood pressure and a rising temperature, spinal puncture should be performed immediately, the pressure recorded and the presence of blood determined. This would seem more satisfactory and avoids subjecting the patients to unnecessary disturbances. It may seem superfluous to state that if the patient is progressing favourably an acute hæmorrhage is not likely to be present, but occasionally zealous resident medical officers have called in their corresponding surgeons to a so-called case of middle meningeal hæmorrhage when the patient is quite conscious and looking well. The signs of a poor prognosis are given as increasing coma, rising temperature, irregular, rapid or Cheyne-Stokes respiration, increasing pulse rate, falling blood pressure, loss of sphincter control, dilated or pinpoint pupils and the absence of corneal reflexes. Their significance should be remembered, but their occurrence should be avoided if possible. In most cases of head injury there is a combination of pathological lesions, such as contusions, lacerations, œdema and hæmorrhage, and unless hæmorrhage has occurred surgery is of little value even though the intracranial pressure is high. Repeated lumbar punctures are of much greater value.

In times of peace compound fractures of the skull vault are uncommon and it was not until the war of 1914-1918 that the treatment of that condition was put on a sound basis by Harvey Cushing. Since then slight changes have been introduced, such as the more conservative removal of skull and brain tissue, the use of chemotherapy, and the realization that such patients stand transportation much better before than they do soon after operation. This latter fact, especially, is now being applied to the treatment of casualties in the present theatres of war.

The importance of anti-shock treatment in cases of compound fracture of the skull has also been stressed by J. T. B. Carmody,[1] who favours the intravenous use of hypertonic glucose solutions (in amounts of 200 millilitres of 25% solution) and blood transfusions if there has been any severe loss of blood. These patients often do not suffer from increased intracranial pressure, for decompression tends to occur naturally in their case either by extrusion of damaged brain tissue or by the loss of cerebrospinal fluid; and accordingly, many of these severely injured patients are conscious. Although admitting that morphine is generally contraindicated in the treatment of head injuries (morphine increases the intracranial pressure, depresses the respiratory centre and causes contraction of the pupil, all undesirable in the presence of a head injury), Carmody recommends small doses of morphine combined with paraldehyde for the treatment of the restlessness of these patients. He suggests the use of paraldehyde in doses of two to four drachms *per rectum*; the use of larger doses of this drug or of "Sodium Luminal" in doses of three grains by intramuscular injection would have obviated the necessity for the use of morphine.

Compound fractures of the skull due to penetrating wounds are not so common among the wounded of this present conflict as would have been expected. T. H.

[1] THE MEDICAL JOURNAL OF AUSTRALIA, April 11, 1931.
[2] *The American Journal of Surgery*, September, 1942.

[1] *The American Journal of Surgery*, September, 1942.

Ackland[1] reports 38 such lesions among 2,767 battle casualties and similar figures have been given by other authors. Nevertheless, considerable interest is now being shown in their treatment and may be expected to result in a lowering of the mortality rate among these patients.

TOXIC BLOOD LEVEL OF SULPHANILAMIDE FROM LOCAL APPLICATION.

IT is usually assumed that, since sulphanilamide has a limited solubility, there is little danger that local application will produce too high a concentration in the blood stream. The following case history, recorded by R. G. Gordon and V. H. Bowers,[2] is therefore of interest, since it shows that a high level of sulphanilamide in the blood was reached after local application to burned areas. The patient, admitted to hospital four hours after he had been burned by an explosion of petrol, was suffering from burns involving the whole of the right hand and arm, part of the left hand, left arm, face and neck, about half of the back of the chest, and part of the front of the chest and dorsum of the penis. The burns appeared to be cutaneous only and were called second degree. On admission the burned areas were covered with dry gauze bandages. These were removed by wetting with saline solution, the burned areas were gently cleaned, and fragments of dead skin were cut away. The areas were then covered with a film of sulphanilamide powder from an insufflator, and dressed with *tulle gras* gauze moistened with saline solution and cotton wool. This was repeated on the day after admission to hospital and again on the second day. The level of sulphanilamide in the blood was estimated on the second day and found to be 29 milligrammes *per centum*. Later on in the same day, it was found to be 59 milligrammes *per centum*. The patient was cyanosed, drowsy and confused. Next day the amount of sulphanilamide in the blood was 30 milligrammes *per centum*, and thereafter it gradually diminished. The patient recovered completely.

It is believed that a concentration of 10 milligrammes *per centum* in the blood stream is sufficient, when sulphanilamide is being used, to combat infections with the hæmolytic streptococcus. Concentrations higher than 15 milligrammes *per centum* are considered undesirable. Clearly it is just as necessary to estimate the amount of sulphanilamide in the blood stream when the drug is applied locally as when it is given by mouth, or parenterally.

CARCINOMA OF THE PANCREAS.

CARCINOMA of the pancreas is a lesion which remains localized for many months. During the past few years it has been shown that advantage may be taken of this characteristic and radical cure performed. The inaccessibility of the pancreas and its juxtaposition to important structures have deterred many surgeons, but a few of the more valiant have been willing to intrude and to give the sufferers of carcinoma of the pancreas a chance of cure. The possibility of cure has been enhanced by the use of bile salts and vitamin *K* before operation, the use of anti-shock measures during and after operation, the development of improved operative procedures, and last but not least the earlier diagnosis of this disease. To help in the earlier diagnosis J. Edward Berk[3] has recently reviewed the symptoms of carcinoma of the pancreas and has stressed the fact that although jaundice is usually regarded as the most common and characteristic feature of carcinoma of the pancreas, pain and loss of weight are really the outstanding early symptoms of this disease. The pain is said to vary in character from a mild steady dull pain to a severe colicky pain, but all variations may occur. The pain may be situated in the epigastrium, in the right hypochondrium or in the lumbar region; but no type of situation of the pain is pathognomonic. Occasionally the pain may exhibit the classical periodicity of a peptic ulcer. In Berk's series only 13·8% of patients showed painless jaundice throughout the period of observation to the time of death. This is certainly contrary to expectations and contrary to the teachings of most people. So also is the fact that in few of Berk's cases was the gall-bladder palpable before operation. This does not mean that the tenets of Courvoisier's law are no longer maintained, but rather that it is applicable to operative findings. The other interesting point that Berk makes is that at least 6·9% of patients with primary carcinoma of the pancreas had antecedent *diabetes mellitus*. Skiagrams have been put little used in the diagnosis of carcinoma of the pancreas for the reason that positive radiological signs are not usually present till late in the disease; but in some obscure cases considerable help may be derived from the finding of obstruction at some part of the duodenum, usually the third part, or at the pylorus with stasis in the proximal parts, of irregularity and deformity of the duodenum by infiltrative encroachment and of widening of the sweep of the duodenum. The question of early diagnosis of carcinoma of the pancreas has also recently been discussed by J. G. Schnedorf and T. G. Orr[4] who reached conclusions similar to those of Berk.

Halstead's successful excision in 1898 of a fungating periampullary carcinoma of the duodenum by a trans-duodenal route with reimplantation of the common bile duct and the pancreatic duct into the duodenum was the forerunner of many similar successful operations. It was but a short step to partial pancreatectomy and this was first performed successfully for carcinoma of the pancreas by A. O. Whipple, W. B. Parsons and C. R. Mullins.[5] Since then other reports have gradually appeared, such as those of A. O. Whipple,[5] C. Dennis[6] and G. Gordon-Taylor,[6] with gradual improvement in the technique, although this operation still remains one of great technical difficulty. Berk calculated that carcinoma of the pancreas causes 1% to 2% of all deaths in the population at large. If this is so it behoves us to give the patients the benefits of earlier diagnosis and the chance of cure in the hands of a surgeon capable of performing and willing to perform these operations, and as Gordon-Taylor concluded, the younger generation should be encouraged to attempt to produce cure and not merely palliation.

NEEDLES FOR THE WITHDRAWAL OF BLOOD.

OF late years so much blood has been collected for transfusion, throughout the world, that methods of collecting it have been studied, improved and, so to speak, speeded up. Part of this speeding up has been a tendency to use very large needles, larger perhaps than some workers consider necessary. L. W. Diggs, with true American enthusiasm and energy, has made investigations to find out and has drawn graphs to show just how large a needle should be used.[6] His is an ingenious piece of work; and certainly objective records are better than subjective impressions whether of donor or doctor. Diggs concludes that in the collection of blood from unselected and consecutive donors by the gravity method, 15-gauge needles proved to be the most efficient for women and 14-gauge needles the most efficient for men. For all-round use the 15-gauge needle is recommended. Needles of gauge 13, 16 and 17 gave inferior performances; Diggs states that the 13-gauge needles are more expensive than smaller needles, are harder to sharpen, have a bad psychic effect on the donor because they look so big and produce a wound which is likely to bleed after the needle is withdrawn. The time taken to collect blood with 14-gauge and 15-gauge needles was not significantly longer than with needles of 13 gauge.

[1] *The Australian and New Zealand Journal of Surgery*, April, 1942.
[2] *The Lancet*, October 24, 1942.
[3] *Archives of Internal Medicine*, September, 1941.
[4] *Annals of Surgery*, October, 1941.
[5] *Annals of Surgery*, Volume CII, 1935, page 763.
[6] *Annals of Surgery*, October, 1941, page 612.
[7] *Surgery*, August, 1942.
[8] *British Medical Journal*, August 1, 1942.
[9] *The American Journal of Pathology*, October, 1942.

Abstracts from Medical Literature.

RADIOLOGY.

Granulomatous Jejuno-ileitis.

MAREY L. SUSSMAN AND EMANUEL WACHTEL (*Radiology*, July, 1942) state that when the X-ray appearance of the jejunum and ileum is abnormal, differentiation between inflammatory and deficiency disease may be difficult, but an acute clinical course, involvement of the terminal portion of the ileum, the presence of segments of normal bowel separating diseased areas, stenosis and serration in outline suggesting ulceration indicate an inflammatory process. An abnormal pattern in deficiency states often is associated with clinical evidence of avitaminosis, while ileo-jejunitis has few definite signs of intestinal insufficiency. This difference in the clinical picture, in spite of diffuse involvement of the small bowel in both conditions, may be due in some cases to the relatively short duration of the infectious type, and in others to the presence of "skip areas" of normal small bowel. As the disease advances into the chronic phase, intestinal insufficiency may supervene, though usually not to a severe degree, and may be relieved in some cases by the administration of anti-anæmic or anti-sprue factors. Hence there may be considerable clinical improvement while the findings on X-ray examination continue to suggest progression of the disease. Differentiation of the condition from an extensive or recurrent and progresaive "terminal ileitis" with "skip areas" of normal small bowel is, of necessity, extremely difficult or impossible. Indeed the disease may be the same. However, the absence of fistulæ and abscesses, the extensive involvement of jejunum and ileum, as well as the fact that in a fair proportion of cases the terminal portion of the ileum is not involved, suggest a classification distinct from terminal ileitis.

Hodgkin's Disease and Lymphosarcoma in Bone.

J. O. VIETA, H. L. FRIEDELL AND L. F. CRAVER (*Radiology*, July, 1942) state that bone involvement by Hodgkin's disease and lymphosarcoma is not uncommon and represents an important complication of these two diseases. The lesions are most frequently found in the pelvis, vertebræ, ribs and femora, and in most cases involve more than one bone. In a survey made by the authors the lesions were predominately of the mixed type in Hodgkin's disease, 57% showing a combination of osteoplastic and osteolytic changes. In lymphosarcoma, however, 85% were entirely osteolytic. The lesions in Hodgkin's disease were more numerous, involving a greater number of bones, but the lesions of lymphosarcoma were more invasive and more widely scattered over the skeleton. The character of the bone lesions, together with features of the clinical course, is distinctive in each of these diseases, yet may not be considered sufficiently clear-cut for sharp differentiation. Bone lesions in Hodgkin's disease and lymphosarcoma occurred at any point during the course of the disease. In lymphosarcoma, bone lesions were found to develop in 63% of the patients in the final one-third of the disease span. In contradistinction to this, in only 31% of the patients with Hodgkin's disease did bone lesions appear during this portion of the course. This is of prognostic significance and would indicate that development of bone lesions in lymphosarcoma is often a terminal event.

Endothelioma of the Pleura.

HOWARD P. DOUB AND HORACE C. JONES (*Radiology*, July, 1942) state that in the early stages of endothelioma of the pleura the X-ray examination usually discloses a diffuse clouding of the affected area suggesting a pleural reaction with or without fluid. This usually occupies the basal or axillary areas of the chest. It is not circumscribed and has no characteristic appearance. As the lesion continues to develop, the opacity of fluid becomes apparent. When the fluid is withdrawn it reaccumulates rapidly and this fact may be the first suggestion of the presence of a neoplasm. In most instances the lung film fails to disclose the tumour nodules, although occasionally one or more may be seen above the fluid level. If the diagnosis is not made at this time, the tumour may develop to the point of invading the lung and producing an almost solid mass. The heart and mediastinum may be displaced to the opposite side by the fluid and growing tumour. One of the most useful procedures in the diagnosis of these tumours is the introduction of air, immediately following withdrawal of fluid, to produce an artificial pneumothorax. In films of the chest made in the postero-anterior and lateral projections as soon as possible after the air has been introduced, multiple tumour nodules are often clearly outlined in a manner which is otherwise impossible.

X-Ray Manifestations of Adult Toxoplasmosis.

L. R. SANTE (*American Journal of Roentgenology*, June, 1942) states that clinically the adult type of toxoplasmosis has little if anything in common with the infantile form of the disease. The earlier pulmonary manifestations may perhaps be best described as an appearance of acute pulmonary congestion with œdema of the lungs. There is accentuation of the hilar shadows with an increase in the size and number of the lung markings radiating outward from the hilar regions into both lungs, but stopping short of the parenchymal structures. There is, in addition, the blotchy, blurred appearance seen in acute œdema of the lungs. The picture at this stage of the disease is similar to that seen in passive congestion with pulmonary œdema, but without cardiac enlargement. Any disease process of the lung which produces primary interstitial involvement may give a similar X-ray picture. For instance, aspiration of irritating material such as kerosene produces acute congestion from irritation followed by acute œdema of the interstitial tissues. Aspiration of less irritating substances, such as water, in drowning, might be expected to cause a somewhat similar X-ray picture, but this changes rapidly. Perhaps the lesion which might most nearly simulate the lung condition, and therefore produce a similar X-ray picture, would be acute œdema of the lungs from the water-logging caused by excessive forcing of fluids in post-operative conditions. At a more advanced stage of the disease the picture changes. The accentuated lung markings radiating outward into the lungs from the hilar regions are no longer the predominating features; they become overshadowed by the increasing interstitial infiltration and alveolar exudation. The composite picture is one of conglomerate areas of infiltration crowding upon each other to give the appearance of irregular blotchy consolidation of the lung. The site of greatest involvement seems to be the lower lobes. The X-ray picture at this stage, if considered without regard to the clinical manifestation, may be readily simulated by any of the atypical pneumonias, or by any of the myotic infections. Extreme œdema of the lungs from any other cause may be mistaken for this condition. Toxoplasmosis, however, is more acute and the symptoms are more grave.

Toxoplasmic Encephalomyelitis.

C. G. DYKE *et alii* (*American Journal of Roentgenology*, June, 1942) state that infantile toxoplasmic encephalomyelitis occurs in young infants of either sex who show symptoms and signs soon after birth or are born with hydrocephalus. They may have convulsive seizures, progressive enlargement of the head, increased intracranial pressure, microphthalmos and manifestations of involvement of many areas of the nervous system. Focal chorioretinitis, a striking feature of the disease, occurs in both eyes. Some of the patients die during the first months of life, while others survive with ocular and cerebral defects. Miliary granulomata, composed of epithelial cells without necrosis or giant cells, are scattered throughout the central nervous system, and are a characteristic feature of the disease. Diffuse intracerebral calcification is the most striking X-ray evidence of infantile or congenital cerebral toxoplasmosis. It usually occurs in small flecks approximately two millimetres in diameter, or in streaks, particularly in the basal ganglia or thalami. Intracerebral calcification was noted in eight of the nine patients whose skulls were examined by X rays. Evidence of increased intracranial pressure was noted in four of the cases. Three of the patients who were examined by pneumoencephalography showed marked internal hydrocephalus. Multiple cerebral calcification in infants and young children makes it imperative that the diagnosis of toxoplasmosis be seriously considered. Pneumonitis may occur in the disease, and in one case toxoplasma was demonstrated at necropsy to be the cause of the pulmonary inflammation.

PHYSICAL THERAPY.

Treatment of Epithelioma of the Skin of the Ear.

J. R. DRIVER AND H. N. COLE (*American Journal of Roentgenology*,

July, 1942) believe that uncomplicated cases of epithelioma of the ear are just as amenable to treatment by approved methods as similar cases on any other area of skin. It is true that recurrent epithelioma in the region of the ear may be extremely difficult to cure. Failures usually have resulted from faulty or insufficient early treatment. The authors' study is based upon the results of treatment in 130 cases of epithelioma involving the skin of the ear. In 86 of the cases the lesions were present on the helix or posterior axillary fold. Biopsies were performed in 71 out of the 130 cases. Of the tumours that primarily involved the ear and were examined by biopsy, 26·6% were basal cell in type. This is a somewhat higher percentage than is often reported. The treatment of epithelioma of the ear cannot be standardized. Each case must be considered individually. The presence of cartilage in uncomplicated cases does not contraindicate the use of properly selected radiation therapy. Radiation therapy at medium or high voltage may be used. Radium interstitial irradiation with heavily filtered radium needles with low intensity can be employed, and in this series was used in the more extensive infiltrating or recurrent lesions. For small lesions the expert use of electrodesiccation or of electrocautery and curettage is satisfactory and good cosmetic results are obtained. Complications requiring skilful handling are present in extensive deep ulcerated and infected lesions with cartilage invaded or destroyed. Heavily filtered radiation or electrosurgery may be indicated. Properly treated by the newer methods, many patients whose condition was formerly considered hopeless, are now cured. Of the group of 107 patients who were followed for more than one year, 94 or 87·9% appeared possibly cured for periods of from one to five years or more.

Radiotherapy and the Cancer Act in Great Britain.

RALSTON PATERSON (*British Journal of Radiology*, October, 1942) points out that application of the *Cancer Act* of 1939 in Great Britain in the immediate post-war years promises to have a profound influence on the future of radiotherapy. To one who is familiar with what is happening today it is only too apparent that effective treatment in the early stages is the exception rather than the rule. There may be delay in the patient's transit to treatment. He himself may delay seeking advice through fear, his practitioner may cause delay through lack of experience of the appearance of early cancer, or the hospital through the operation of a waiting list. Another factor is that cancer is still looked upon as merely one of the diseases included in the scope of general medicine and surgery and even then almost as one of the chronic diseases. The method of treatment to be adopted is determined far more by the accident of the type of consultant to whom the patient is referred, than by any adequate consultative organization. The execution of the treatment is seldom in the hands of anyone with really extensive experience of a particular technique. It must be admitted that in the group of diseases generally called cancer, there is still a large fraction which is incurable. However, the established achievements of surgery and radiotherapy have given us valuable weapons and certain types of cancer can be cured with some degree of consistency. If improvement is to be achieved, two general principles will have to become well established in any new organization. The first is that once cancer is suspected, action should be immediate. The second is that all specialists concerned with diagnosis and treatment should be engaged in cancer work to such an extent that they really have special experience in that group of diseases. These ends can be realized only by the creation of special radiotherapy institutes, departments or coordinating organizations, so as to ensure that adequate numbers of patients will be dealt with as one group, and that enough radium and a sufficiently large X-ray plant will be segregated for the necessary flexibility of technique. The greatest gain, however, is the bulk experience in the specialty gained by a small number of individuals working as members of a group. The two main sections of the cancer hospital will be the radiotherapy section and the surgical section (including the various specialties). It is impossible to have any separation between radium therapy and X-ray therapy and both must be in the hands of the radiotherapeutist. Trained therapists of today have been recruited about equally from the ranks of surgeons via an interest in radium and from the ranks of radiotherapeutists via deep X-ray therapy. As well as transference of control of radium work from surgeons to therapists in the major centres, there must be a similar transference of control of X-ray therapy for malignant disease from the radiodiagnostician to the radiotherapist. On the surgical side, the ideal is complete centralization to the surgical section of a separate cancer department or hospital with its selected staff small in number but genuinely experienced. The author asks how the final decision as to the method of treatment is to be arrived at and put into operation. Much vague talk exists about every patient being seen by a "full team of specialists". The author questions the real value of this. In general what is required is consultation between two people, usually the surgeon and the radiotherapist. Such consultation between the two specialists should be planned to be automatic and regular and the two should meet on terms of absolute equality. Once a decision has been reached as to diagnosis and method of treatment, the patient should finally pass into one person's hands entirely as his complete clinical responsibility, further consultations being sought as indicated. The method of organization of cancer diagnostic services is also discussed in detail.

Pre-operative Irradiation in the Treatment of Osteogenic Sarcoma.

NORMAN L. HIGINBOTHAM AND BRADLEY L. COLEY (*American Journal of Roentgenology*, June, 1942) report on 114 cases of true osteogenic sarcoma occurring in patients admitted to the Memorial Hospital, New York, during the period January, 1935, to January, 1941. Fourteen of these patients lacked microscopic proof of the disease, and in 31 cases irradiation methods were not employed; 69 proved cases were thus available for this analysis of irradiation methods and their effects. A sufficient number of cases has been studied to justify the conclusion that at least 4,000 *r* must be delivered to all parts of a tumour to destroy it. In most cases a fractionated dose technique was employed with a current of 200 kilovolts, but in three cases 1,000 kilovolts were used. In the routine management of these cases microscopic confirmation is obtained by aspiration biopsy and occasionally, if necessary, by operative biopsy. The pre-operative deep X-ray therapy is then planned. The subsequent amputation should always be performed well above the demonstrable tumour. The effects of the irradiation on the symptoms presented by the patient are also described. Pain is the predominating symptom and it is a universal experience to note partial or complete relief of pain in practically all cases. This degree of relief varies with the individual and with the type of osteogenic sarcoma. With regard to the effect on the skin, it should be noted that the treatment must at times be courageous. As a first prerequisite a large total dose must be delivered to all parts of the tumour. The time interval between the last radiological treatment and amputation will vary according to the skin reaction and consequent healing, but usually from two to six weeks are required. There are many sub-varieties of osteogenic sarcoma with wide variation in radiosensitivity. While in general the osteogenic chondro-sarcomata are markedly radioresistant, occasionally a satisfactory response is obtained. The sclerosing type is also usually quite radioresistant. On the other hand the periosteal and subperiosteal types as well as the cortical and medullary osteolytic lesions may show remarkable response to irradiation. It has been found that in children the sarcomata are more anaplastic and hence more radiosensitive, but tend to metastasize early. It has been shown that in patients with osteogenic sarcoma having elevated serum phosphatase values, the changes in phosphatase level afford a prompt indication of the effect of radiation therapy. Adequate amounts of irradiation cause an appreciable drop in the serum phosphatase through partial or complete inactivation of the phosphatase-producing mechanism in the tumour. The conclusions are: (*a*) Irradiation alone should not be relied upon in the treatment of osteogenic sarcoma. (*b*) In some cases, notably those of adults with radiosensitive tumours, immediate amputation remains the treatment of choice. (*c*) Some osteogenic sarcomata are somewhat radiosensitive and in these cases the treatment should be carefully planned pre-operative radiation therapy followed by amputation. In inoperable cases irradiation alone may be given for its palliative effect. The programme of irradiation must be arranged to suit the requirements of the individual problem presented, and a total tissue dosage given of at least 4,000 *r*. Post-amputation irradiation has not been considered as it is very seldom if ever indicated. Irradiation of the lung fields for pulmonary metastasis is of questionable value, from either the prophylactic or the therapeutic point of view.

British Medical Association News.

MEDICO-POLITICAL.

ANNUAL MEETING OF THE DELEGATES OF THE AFFILIATED LOCAL ASSOCIATIONS OF MEMBERS WITH THE COUNCIL OF THE NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE annual meeting of delegates of the local associations affiliated with the New South Wales Branch of the British Medical Association was held in the William H. Crago Council Room, British Medical Association House, 135, Macquarie Street, Sydney, on December 4, 1942, DR. W. F. SIMMONS, the President, in the chair.

The following delegates of local associations were present: Dr. B. Funder (Broken Hill Medical Association), Dr. H. A. McCredie (Canterbury-Bankstown Medical Association), Dr. O. J. Ellis (Central Northern Medical Association), Dr. R. O. Williams (Central Southern Medical Association), Dr. K. S. M. Brown (Central Western Medical Association), Dr. N. E. McLaren (Eastern District Medical Association), Dr. B. W. Stevenson (Eastern Suburbs Medical Association), Dr. G. F. Elliott (Illawarra Suburbs Association), Dr. R. J. Jackson (Northern District Medical Association), Dr. R. J. Ryan (North-Eastern Medical Association), Dr. N. F. Benjamin (Southern District Medical Association), Dr. A. L. Caselberg (South-Eastern Medical Association), Dr. C. H. Jaede (South Sydney Medical Association), Dr. M. H. Elliot-Smith (Warringah District Medical Association), Dr. H. M. Rennie (Western Suburbs Medical Association), Dr. S. R. Dawes (Western Medical Association).

The following members of the Council of the New South Wales Branch were present: Dr. George Bell, Sir Charles Blackburn, Dr. K. S. M. Brown, Dr. A. M. Davidson, Dr. L. A. Dey, Dr. B. T. Edye, Dr. P. L. Hipsley, Professor H. K. Ward, Dr. W. Vickers

Dr. H. Hunter (Assistant Medical Secretary) was present and the Editor of THE MEDICAL JOURNAL OF AUSTRALIA also attended.

Welcome to Delegates.

Dr. W. F. Simmons, the President, welcomed the delegates. He said that the annual meeting of delegates was valuable, both to the Council of the Branch and to the general body of members. He explained that voting would be by the delegates only and not by the members of Council; this was in accordance with the established practice.

Friendly Society Lodge Practice.

The Income Limit in the Common Form of Agreement.

Dr. B. W. Stevenson moved and Dr. K. S. M. Brown seconded the following motion:

> That, having regard for the greatly increased earnings of many members of friendly societies receiving medical benefits, steps be taken by lodge secretaries, after thorough investigation of the financial status of members, to remove from medical benefit lists the names of those members not entitled to medical service under the Common Form of Agreement income limit clause.

In proposing the motion, Dr. Stevenson explained that his association had been concerned over the matter for some time. They had intended to write to the lodge secretaries about it, but in view of the proposed discussion on the extension of contract practice they had refrained from doing so. It was obvious that something would have to be done. Wages were rising and the wives of members were earning. Many lodge medical officers were away on active service, and he thought that lodge members who were in receipt of large wages should be put off the lists so that *bona fide* members might be placed on them. He also did not think it fair that lodge medical officers should provide a service for those who were in receipt of £10 or £12 a week.

Dr. N. F. Benjamin said that the motion opened up a big subject. He foresaw that before long some attempt might be made to alter the Common Form of Agreement. He thought that it would be better to discuss this subject together with the proposed extension of contract practice, and moved an amendment to that effect. The amendment was seconded by Dr. O. J. Ellis, and after discussion, in which Dr. A. O. Caselberg and Dr. C. H. Jaede took part, was carried.

The Common Form of Agreement.

Dr. B. W. Stevenson moved and Dr. R. J. Ryan seconded the following motion:

> That lodge secretaries should be requested to provide the correct addresses with the names of members on medical lists.

Dr. K. S. M. Brown and Dr. H. M. Rennie opposed the motion, the latter declaring that the proposal, if carried, would add to the work of the secretaries. Dr. O. J. Ellis supported the motion and Dr. M. H. Elliot-Smith said that the addresses should be asked for even if it was a little difficult for the secretaries to supply them. Dr. N. F. Benjamin said that it was absurd that the lodge medical officer should not be supplied with the addresses of his patients. If they were supplied the efficiency of the lodge service would be increased. Dr. C. H. Jaede supported the motion; his association suggested that the address should be placed in the back of the patient's lodge book. The motion was carried.

The Closure of Lodge Lists by Medical Officers.

Dr. L. A. Dey, on behalf of the Medical Politics Committee of the Branch Council, moved that consideration should be given to the closing of lodge lists by medical officers. He said that some lodge medical officers were doing this on account of the enormous amount of work that they had been called upon to do in the absence of lodge medical officers engaged on active service. The result was that some of the older lodge members could not obtain service. Dr. Dey's motion was seconded by Dr. K. S. M. Brown and carried.

Dr. R. J. Jackson said that lodge medical officers in the country were faced with big lists and it was the view of his association that it was part of the doctor's contribution to the war effort to keep the lists open. Dr. O. J. Ellis recognized that the large lists must be a serious handicap in the metropolitan area, but he thought that any extensive closing of the lists might help to precipitate a nationalized medical service. Dr. M. H. Elliot-Smith thought that the question should be left to the individual doctor to decide. Sometimes it was a matter of the doctor's health, who could not possibly do more than a certain amount of work. He thought that perhaps it might be well to state a principle and leave the decision to the individual doctor. One delegate referred to an area in which one practitioner had closed his list and the other three practitioners in the district had promptly done the same. Dr. H. A. McCredie said that the difficulty could not be overcome by coercion. Dr. C. H. Jaede thought that the lodge lists should not be closed during the present period. Dr. B. W. Stevenson said that the lodge work should be evenly distributed and should be undertaken even by practitioners who had not previously engaged in lodge practice. Dr. K. S. M. Brown felt a certain amount of sympathy for those who wanted to close their lists, but thought that they should take transfers and junior lodge members.

Dr. C. H. Jaede moved a motion to the effect that in the opinion of delegates lodge lists should not be closed. This was seconded by Dr. K. S. M. Brown. Dr. R. J. Jackson said that if this was passed, some words to the effect of its being a wartime measure should be added to the version.

Dr. G. F. Elliott moved an amendment which stated that no lodge list should be closed without reference to the Council. This was seconded by Dr. M. H. Elliot-Smith. At this point Dr. C. H. Jaede raised a point of order and asked whether it was within the power of any lodge medical officer to close his lists. In reply to this question, the President said "no". He added, however, that it was possible to have a conference with the friendly societies in the matter. The Assistant Medical Secretary said that the friendly societies realized the seriousness of the position, and added that if the matter was referred to the Council, the Council would take it up with the friendly societies. Dr. Elliott's amendment was put to the meeting and carried.

The Evacuation of the Families of Lodge Members to the Country.

Dr. N. F. Benjamin moved:

> That the question of doctors' remuneration for lodge evacuees from city to country areas be considered with special reference to the evacuation of portions only of families.

The motion was seconded by Dr. A. L. Caselberg *pro forma*. Dr. O. J. Ellis said that his association was opposed to the splitting of the fees. Dr. R. O. Williams said that the members of his association were not affected a great

deal by this question—the situation with them was by no means acute. After further discussion, in which Dr. R. J. Jackson took part, Dr. Benjamin was allowed to alter the wording of his motion, which was adopted in the following form:

> That the question of doctors' remuneration for lodge evacuees from city to country areas be kept in mind by the Council of the British Medical Association (New South Wales Branch), with special reference to the evacuation of portions only of families.

Assistance for Lodge Medical Officers.

Dr. N. F. Benjamin referred to the problem of the increasing size of lodge lists. He said that the question had really been mentioned in the discussion on the first motion by Dr. B. W. Stevenson. He moved:

> That where the problem of the increasing size of lodge lists is acute, the State Medical Coordination Committee be asked to attempt to obtain help from the medical officers of the Services.

Dr. Benjamin explained that practitioners in Wagga had asked for help from medical officers of the Services, but that this had been refused. The motion was seconded by Dr. O. J. Ellis.

Dr. M. H. Elliot-Smith was in general agreement with the motion, but thought that requests should be made for assistance for those practitioners whose lodge lists increased to a point at which it was not possible for them to be adequately dealt with. He moved an amendment to this effect, and the amendment was seconded by Dr. G. F. Elliott.

Dr. George Bell explained that the Services would be willing to help, but that the question was not simple. The recommendation should be sent on to the Central Medical Coordination Committee. It would make no difference to the Coordination Committees whether the medical officers concerned were lodge doctors or not.

Dr. N. E. McLaren explained that in his area assistance had already been received from medical officers of the Services. Dr. O. J. Ellis said that Major-General Downes had told his Association that it would be possible to make men available. The amendment, on being put to the meeting, was lost. Dr. N. E. McLaren thought that the original motion should be altered to include men in private practice who were overworked. Dr. M. H. Elliot-Smith added that it would be a mistake not to ask for help from any other source.

After permission had been granted, Dr. N. F. Benjamin and Dr. O. J. Ellis amended their original motion, which was carried in the following form:

> That where the problem of the increasing size of lodge lists is acute, or where general practitioners are overworked or ill, the New South Wales State Medical Coordination Committee be asked to attempt to obtain help from the medical officers of the Services or from any other source available.

The Extension of Contract Medical Service.

On the motion of Dr. L. A. Dey, seconded by Dr. O. J. Ellis, it was resolved that the extension of contract medical service to munition workers and other industrial organizations should be considered.

The Assistant Medical Secretary explained the position which had arisen at Lithgow and the request by workers at munition factories at Bathurst and Orange for contract medical services on similar conditions to those existing at Lithgow. The Assistant Medical Secretary also referred to a statement on the extension of contract medical practice which had been drawn up by the Branch Council and had been published in the report of the recent meeting of the Federal Council in THE MEDICAL JOURNAL OF AUSTRALIA of November 14, 1942.

Dr. C. H. Jaede expressed the opinion that it was necessary in any extension of contract practice to observe an income limit. If contract practice was undertaken without an income limit, it would be dangerous. Once it was allowed that no income limit would operate in a given area, or in a certain set of circumstances, other persons in different situations would ask for the same concession. It was necessary to have both an income limit and a preliminary examination of those accepted for contract practice medical attention. He agreed that some allowance should be made for the number of dependants. Dr. R. J. Jackson said that his association agreed that an extension of contract practice was necessary, and thought that it should be undertaken in terms of the Federal Common Form of Agreement. It should be a temporary service to cover munition workers, workers for the Allied Works Council and other similar bodies. An income limit should operate, and no overtime should be included in the computation of an income. Dr. O. J. Ellis was in general agreement with Dr. Jackson's views. Any agreement should be in terms of the Federal Common Form of Agreement, an income limit should operate, overtime need not be considered in its computation, and a preliminary examination might be waived for the duration of the war.

Dr. N. F. Benjamin agreed with most of the statements that had been made; he added, however, that there were many persons in lodges who should not be there, and in his opinion these should be discovered and asked to resign. The figure of 2·5 for a lodge member and his family should be increased; there was a great deal of midwifery at present. The preliminary examination should be continued. In addition, there were some features of lodge practice which should be altered. In the first place, evening consultation hours should be curtailed. In the second place, lodge members should be made aware that under the terms of the agreement they were liable to be charged for special services; many lodge members were surprised when they first discovered this, and Dr. Benjamin thought that the lodge secretary should make it his business to tell the lodge members about such charges. In the third place, a smaller contribution should be accepted from a single person than from one who was married.

Dr. M. H. Elliot-Smith said that his association agreed with the need for extension. In regard to an income limit, he thought that one should operate, but that it should not be more than twice the amount of the basic wage, Federal or State. Dr. Elliot-Smith also referred to the Queensland formula, in which the lodge contribution varied in accordance with variations in the basic wage. The scope of the service should be the same as that set out in the Common Form of Agreement, and he thought that the Council should be asked to explore the possibility of the inclusion of ancillary services in contract practice. The rate of remuneration should be in the neighbourhood of £2 10s. per family unit. Further, the preliminary examination should be continued, as it was a protection both to the lodge and to its medical officer.

Dr. G. F. Elliott thought that remuneration should vary with the basic wage and that the family group for this should be the basis of payment. The service should be based on the Common Form of Agreement. Dr. A. L. Caselberg referred to the difficulties of medical officers who did their own dispensing. Dr. B. W. Stevenson said that his association wished to oppose the extension of contract practice during the war. By no scheme was it possible to increase the service which doctors were giving to the community. The health of the medical profession had to be considered.

After further discussion the President explained to delegates the views of the Federal Council. It was resolved on the motion of Dr. M. H. Elliot-Smith, seconded by Dr. O. J. Ellis:

> That this meeting of delegates approves of the principle of the extension of contract medical services to munition workers and other wartime industrial organizations under suitable conditions as a wartime measure.

It was also resolved on the motion of Dr. A. L. Caselberg, seconded by Dr. H. A. McCredie:

> That the model Federal Common Form of Agreement as drawn up by the Federal Council in June, 1940, should be implemented at once.

Dr. C. H. Jaede moved and Dr. O. J. Ellis seconded a motion which stated that any contract practice, other than friendly society contract practice, required from members of the Branch could be accepted by members only after permission had been obtained from the Council and on terms and conditions according to the model Federal Common Form of Agreement.

Dr. R. J. Jackson said that this proposal affected members of his association. He referred to attempts by students in Armidale at the Teachers' College and at the University College to secure for themselves some contract form of medical service. A list of fees to be charged had actually been drawn up and referred to the Branch Council. The Council had refused to allow such a service to be created, and the members of the local association had been unable to discover how their proposals should be amended to make them acceptable. The fees which were to be charged under

this proposed scheme came from the students themselves. It was not possible to compare these students, many of whom paid their own fees, with persons who were members of lodges and received service in terms of the Common Form of Agreement. As a matter of fact, the service would be required only while the students were in Armidale, which would be for about thirty weeks of the year. The local association had made these inquiries of the Branch Council three years previously; they had been waiting for an answer and were asking for one again now.

The Assistant Medical Secretary said that this question raised the whole subject of insurance—it involved the principle of the spread of the insurance risk. Dr. A. L. Caselberg asked whether it was wise to allow such variations to be established. Within three months extensive changes in contract practice generally might take place. He certainly thought that the approval of the Branch should always be obtained. Dr. C. H. Jaede said that if exceptions were made in one instance, others would crop up in which the same concessions would be demanded. Dr. S. R. Dawes supported Dr. Jaede and said that the rules should be rigid. The Assistant Medical Secretary said that if the scheme referred to by Dr. Jackson was based on service for thirty weeks in a year, it would not necessarily infringe Dr. Jaede's motion. Dr. R. J. Jackson promised to send to the Council full information on the subject. He then moved an amendment substituting the words "a model form of agreement" for "the model Federal Common Form of Agreement". The amendment lapsed for lack of a seconder. The motion of Dr. C. H. Jaede and Dr. O. J. Ellis was then carried.

General Hospitals: Accommodation and Construction.

Dr. B. W. Stevenson moved the following motion:

> That this Association views with alarm the present position regarding accommodation provided by the general hospitals for necessitous cases.

The motion was seconded *pro forma* by Dr. M. H. Elliot-Smith. Dr. Stevenson explained that in the suburbs it was extremely difficult to have patients suffering from urgent conditions admitted into hospital. A motion similar to the one moved by him had been brought forward on a previous occasion, but the matter had been shelved. He thought that something should be done. A great number of beds were kept in case air raids took place; but some of these should be made available in urgent circumstances.

Dr. A. L. Caselberg said that the teaching hospitals took up a dictatorial attitude regarding patients who were really ill. He referred to one man who had a non-functioning or absent kidney. Investigation of the man's condition was urgently required, and repeated attempts were made to have him admitted to one of the metropolitan hospitals. On each occasion the hospital authorities had replied that it was not the province of the hospital to act as a consultant. When at length the hospital was informed that the matter would be brought to the notice of the Hospitals Commission, the patient was admitted within half an hour.

Dr. M. H. Elliot-Smith said that he agreed with the principle behind the motion. He had recently been present at a gathering at which several honorary medical officers of hospitals were present, and when this matter was discussed, resident medical officers pointed out that the hospital in question had plenty of empty beds. He referred particularly to a patient with a fractured leg and another with a strangulated hernia whom he had been unable to place.

Dr. George Bell said that he had expected this motion. Many beds had been "closed" because of the emergency. Dr. Bell thought that the delegates should lay stress on the state of affairs, because the Government should take notice.

Dr. C. H. Jaede said that the important word in the motion was the word "necessitous". If the patient was poor and was likely to be ill for longer than a month, no bed was available. This was especially true of a patient suffering from tuberculosis, who would be lucky if he was perhaps only the seventieth on the waiting list. The unfortunate tuberculous patient was given hope and asked to live on hope alone.

Dr. R. J. Ryan referred to conditions at the Lismore Base Hospital. It was usual for the hospital to have twenty, forty or even fifty patients above its proper complement. The hospital had for five years been "first on the list" for rebuilding; but nothing had been done. A new hospital was, however, being built at Bathurst, which was close to Orange, where there was already a big hospital. Hospital construction should be undertaken according to the demands of the public, and not according to the degree of urging.

After some discussion it was decided that Dr. Stevenson's motion should be combined with another on the business paper, standing in the name of Dr. Ryan, which stated that in view of the fact that serious anomalies existed in the allocation of moneys for hospital building, the Council of the Branch should approach the Minister for Health with a view to having the allocation of money for hospital construction made according to the public needs.

The Assistant Medical Secretary pointed out that one cause of the trouble lay in the lack of "subacute hospitals". If these could be provided, much of the difficulty would be solved. The combined motion was put to the meeting and carried.

It was also resolved, on the motion of Dr. N. F. Benjamin, seconded by Dr. R. J. Ryan, that in any hospital construction undertaken by the armed forces, they should be asked to consult with the hospital authorities in each State with a view to some provision being made for post-war needs.

Mileage Fees.

The Assistant Secretary explained that a letter had been received from the Graziers' Association of New South Wales in regard to the high mileage fees charged by medical practitioners in country districts. On the motion of Dr. B. T. Edye, seconded by Dr. M. H. Elliot-Smith, it was resolved that the matter should be considered.

Dr. R. J. Jackson pointed out that the question had been raised in 1940, when a subcommittee consisting of himself and others was asked to report on the subject. The subcommittee had gone into the question fully, and had drawn up a memorandum. The recommendations of the subcommittee had never been implemented.

On the motion of Dr. R. J. Jackson, seconded by Dr. K. S. M. Brown, it was resolved that the recommendations of the subcommittee should be implemented forthwith.

The Pre-Natal Care of Indigent Women.

Dr. L. A. Dey, on behalf of the Medical Politics Committee, raised the question of the pre-natal care of indigent women. He said that the establishment of pre-natal clinics for indigent women in country towns had been advocated. He moved that the matter should be discussed by the delegates. The motion was seconded by Dr. R. J. Ryan and carried.

Dr. R. J. Ryan said that indigent women in the country would be treated by medical practitioners, and that no special clinics were necessary. He therefore moved a motion to the effect that there was no necessity to establish pre-natal clinics in large country towns. This motion was seconded by Dr. R. J. Jackson, who said that under ideal conditions the women would be admitted to the hospitals at which they had received their ante-natal care. The money to provide treatment for these patients came from public funds in the long run. Many women found it difficult to obtain admission into a public hospital. Dr. Jackson thought that something should be done to facilitate the provisional pre-natal care in out-patient departments and confinement of the patients in public wards. He was in full sympathy with Dr. Ryan's motion, but thought that it went only half-way. Dr. O. J. Ellis supported the motion and thought that treatment in ante-natal clinics should be restricted to indigent patients. Dr. Ryan pointed out that at Lismore there was no out-patient department at the hospital, and Dr. Jackson interjected that there were two kinds of town. He had in mind towns in which hospitals had out-patient departments. Dr. K. S. M. Brown pointed out that it was often stated that ante-natal care was not satisfactory; he thought that the medical arrangements should be so complete that a complaint of that sort could not be raised. Dr. M. H. Elliot-Smith said that the subject had been referred to his local association too late for consideration in detail before the meeting. He thought that the subject should be considered in detail by those who would have to do the work. In his opinion, the matter should be deferred pending further consideration by the local associations. He moved to this effect, and Dr. A. L. Caselberg seconded the motion which was subsequently withdrawn.

After further discussion in which the Assistant Medical Secretary pointed out that it had been impossible to send the information to the local associations at an earlier date, it was resolved, on the motion of Dr. M. H. Elliot-Smith, seconded by Dr. K. S. M. Brown, that the question of the establishment of pre-natal clinics for indigent women should be referred to the Council with a request that it prepare forthwith a suitable scheme for submission to the local associations at the earliest opportunity. This motion, which was an amendment, was then carried as a substantive motion.

Publication of Report of the Meeting of Delegates.

Dr. A. L. Caselberg, on behalf of the South-Eastern Medical Association, moved that the full proceedings of the meeting of delegates should be published in THE MEDICAL JOURNAL OF AUSTRALIA as soon as possible after the meeting. The motion was seconded by Dr. C. H. Jaede. Dr. Caselberg said that the country members knew little of what was going on, and that they should be informed. He thought that possibly a special supplement might be issued.

At the invitation of the President, Dr. A. M. Davidson, one of the Directors of the Australasian Medical Publishing Company Limited, addressed the meeting. He said that he, with others, had sometimes thought that a full account should be published. It had to be borne in mind, however, that THE MEDICAL JOURNAL OF AUSTRALIA circulated amongst non-medical persons and newspapers, as well as amongst medical people, when it was not always advisable that the views of delegates should be broadcast.

The Editor of THE MEDICAL JOURNAL OF AUSTRALIA, on being invited to speak, explained that care was always taken to censor reports of medico-political meetings before they were published. He also said that the postal regulations did not allow a supplement to be issued unless it was included with every copy of the journal sent through the post.

Dr. A. L. Caselberg explained that he wanted an account published, but this account need not necessarily appear in a journal. Dr. R. J. Jackson thought that at present few men had the time to read a full account of the meeting. Dr. K. S. M. Brown thought that most of those present would like to be spared the agony of reading all that they had said. Dr. B. W. Stevenson thought that a full report of the meeting should be sent to each member. The motion, on being put to the meeting, was lost.

The Teaching of First Aid in Schools.

Dr. A. L. Caselberg moved that a course of elementary first aid should be included in the primary school curriculum. He thought that this was most necessary and that a move in the matter should be made by the medical profession. The motion was seconded by Dr. N. F. Benjamin, who said that there were two thousand persons in Wagga with a first-aid certificate. Dr. M. H. Elliot-Smith was in favour of the idea, but thought that the instruction should be confined to senior scholars. The Assistant Medical Secretary pointed out that first-aid instruction was already given in high schools. After further discussion it was moved as an amendment by Dr. N. E. McLaren that a course of elementary first aid should be included in the curriculum of primary and secondary schools for pupils over the age of twelve years. This was seconded by Dr. M. H. Elliot-Smith and carried. It was then carried as a substantive motion.

A Representative Body for Australia.

Dr. O. J. Ellis raised the question of the difficulties experienced in the determination of the policy of the medical profession for the whole of Australia. His association thought that a body larger than the Federal Council and more representative of the whole profession within the Commonwealth might be more effective. He therefore moved:

> That in view of the grave emergency confronting the medical profession in Australia, the time has arrived for the establishment of a Representative Body for the whole of the Commonwealth on the lines of the Representative Body of the Parent Association in England, with power to determine the policy of the profession for the whole of Australia.

Dr. A. L. Caselberg, in seconding the motion, said that he felt unhappy about the Federal Council and thought that it should be the mouthpiece of an elective body. Dr. R. J. Ryan supported the idea. He was of the opinion that a representative body for Australia would eventually be formed. He did not agree with the statement "the time has arrived"—this was not accurate. Dr. A. M. Davidson agreed that something of the kind suggested was necessary. Although the creation of a representative body might be desirable, it had to be remembered that the cost of such a body would be considerable. Dr. R. J. Jackson thought that the multiplication of bodies would mean added troubles. Dr. R. O. Williams said that the national health insurance controversy had shown quite clearly that much more consideration than ever before would have to be given to the views of the rank and file in the profession. He did not think that a representative body would meet the case at present. Events moved so rapidly that a decision might become necessary at a moment's notice. Dr. Ellis, in reply, said that the time for a representative body was the present, and that the members of the Branches must be prepared to pay. The motion, on being put to the meeting, was carried.

A General Medical Service.

Dr. G. F. Elliott referred to the need for keeping medical practitioners on active service informed of the possible implications of the various schemes suggested for the alteration of medical practice, and he moved that the Council should be asked to evolve some scheme by which this could be done. Dr. K. S. M. Brown seconded the proposal, and pointed out that one or two of the local associations were already sending circular letters to their members on active service. Dr. A. L. Caselberg pointed out that there were overseas many young graduates who had never been in practice, and some who were not members. It was important that these men should know what was going on. Dr. Elliott's motion was carried.

Dr. O. J. Ellis moved the following motion:

> That, should a national medical service be contemplated, this meeting of delegates is of the opinion that we should utterly oppose any scheme for a complete salaried service and refuse to take part in such a service. That, if we have to accept a national medical service, we will only agree to a scheme based on adequate *per capita* payments and that we instruct the Federal Council to prepare a concrete scheme for such based on all the evidence available, including the evidence given before the Royal Commission on National Health Insurance. Such scheme to be prepared and submitted to the Branches as soon as possible.

Dr. Ellis said that the National Health and Medical Research Council scheme was pernicious. Under its provisions medical practitioners were asked to sacrifice their freedom. There were some to whom the idea of regular hours on and off duty, and of an annual holiday, would appeal. Dr. Ellis also thought that some men who had already made money would like it. He thought that some unified opinion of the profession was necessary. Dr. Ellis did not agree that the idea of service on a *per capita* basis was dead. In the Newcastle area they had such a scheme, and it worked well. He did not see any reason why it should not work elsewhere, and he thought that a pool might be attached for specialists' services. The Federal Council scheme was good as far as it went, but it was not sufficiently concrete. A concrete scheme should be prepared according to the terms of his motion, and sent to the rank and file of the profession. The motion was seconded by Dr. A. L. Caselberg.

Dr. G. F. Elliott said that six months earlier he had been unable to find a seconder for a motion dealing with a salaried medical service. Today he thought that such a motion would secure a majority. He did not wish utterly to oppose every scheme—it was impossible to oppose utterly any scheme that had not been considered. Freedom was not a matter of *per capita* payment or of income. It had to do with the possession of one's own soul. In England the *per capita* system of national insurance was full of pin-pricks for the medical practitioner. It was stated that under a salaried service in Australia things would be different. Possibly they would, and in any case it would be hard to get men to oppose a salaried service if the salary and the conditions were to their liking. If the present rate of taxation continued, the only freedom that medical practitioners would retain under the present system of practice was a freedom to work for twenty-four hours a day on seven days in a week for what was, after all, a salary. With a salaried service, the medical profession might be directed, it might be controlled, but it need not be dragooned. Conditions were more important than payment. Dr. Elliott concluded by insisting that full information should be given to members regarding a salaried service.

Dr. K. S. M. Brown said that Dr. Elliott had put his case very well. It was important that all the facts should be discovered. There was a good deal to cause confusion. While it was desirable that an answer should be found for those who thought that the salaried system was best, it was important that members should appreciate the revolutionary thought that was going on. The profession should try to evolve the best possible scheme and give the general public something definite.

Dr. A. M. Davidson said that the chairman of his local association had advanced certain arguments in favour of

a salaried service, such as relief from a 24-hour-a-day service, the cutting down of expenses, superannuation, the abolition of professional jealousy and competition, and the provision of post-graduate facilities. Dr. Davidson said that his local association wished to have this motion opposed. He agreed that a salaried medical service should be considered. All the reasons in its favour should be stated and the pitfalls discovered. There was much difficulty about obtaining uniformity. The only way to secure a unanimous opinion was to hold frequent meetings for discussion. It was not correct to say that nothing had been done in the past by the leaders of the profession. The Federal Council had been giving thought to this matter for some years, and it was time that the profession made up its mind on the subject. Quoting a well-known Irish statesman, Dr. Davidson said: "If we do not hang together we shall hang separately." He thought that the appointment of a representative body was essential. Discussion by such a body was the only means by which complete reasons for or against any scheme could be formulated, and it was the best way in which the profession could be consulted. No scheme should be implemented during the war, but whatever scheme was finally put into operation should be controlled by a non-political commission. The final control should not rest with the Minister for Health. In his further remarks, Dr. Davidson pointed out that people would want to select their own doctors and that the abilities and qualities of individual practitioners should be considered. He thought that some specialists would want a salaried service because they did not see why they should spend many hours on many days a week working in hospital out-patients' departments in their honorary capacity, and have only one or two days a week on which to work for themselves. He agreed with Dr. Brown that any scheme put up should be moulded by the medical profession. At the same time, the medical profession should see reason and not see red.

Dr. S. R. Dawes said that there were a variety of opinions in his local association. Some could see merit in a salaried service, and others were entirely opposed to such an idea. He thought that a great deal of study and attention should be given to the subject.

Dr. H. M. Rennie said that at the last meeting of his local association the discussion had taken place round the advantages and disadvantages of a medical service based on a *per capita* payment and a salaried medical service. Dr. Rennie traversed the arguments that had been advanced for and against these schemes, and said that when the matter was put to the vote the voting was even. It was his intention, therefore, not to vote on the matter at the present meeting.

Dr. M. H. Elliot-Smith said that Dr. Ellis's motion was not available for discussion by his local association. The question of a salaried service, however, had been discussed, and the feeling was that members were considering an extension of contract practice as a method of avoiding some other form of national medical service. He had been struck by the extraordinary differences of opinion expressed. On the one hand, a scheme for a salaried service was said to be a young man's scheme, and on the other he knew a practitioner of thirty years' standing who would welcome it. Dr. Elliot-Smith was of the opinion that all plans should be earnestly considered, and he thought that the idea of holding a convention was excellent.

Dr. R. J. Jackson said that a general medical service had been discussed by his local association some months previously. A difference of opinion was expressed. Finally members had decided that they would prefer medical practice to remain as it was, but that if a change was to be introduced, the Federal Council scheme was the one that should be preferred. At the same time, Dr. Jackson agreed that every scheme should be examined. Dr. B. Funder said that he had been asked to refrain from voting on this question. Dr. George Bell said that the discussion had justified the attitude of the Federal Council in asking for a general discussion of the matter and consideration by the Branches.

At this stage Dr. Ellis wished to amend his original motion so that it would read as follows:

> That this meeting of delegates ask the Council of the New South Wales Branch of the British Medical Association to request the Federal Council to prepare a concrete scheme for a national medical service based on adequate *per capita* payments and based on all the evidence available, including the evidence given before the Royal Commission on National Health Insurance, such scheme to be prepared and submitted to the Branches as soon as possible along with other schemes.

Permission to amend the motion was refused, and the original motion, on being put to the meeting, was lost.

Dr. A. L. Caselberg then moved the following motion:

> That a convention consisting of delegates from the local associations and the Council of the British Medical Association be called immediately to formulate the best scheme for a national medical service and that such scheme shall be presented by the Council of the New South Wales Branch to the Federal Council as the opinion of this Branch.

Dr. Caselberg said that the discussion that had already taken place showed that it was necessary to hold a convention. The motion was seconded by Dr. K. S. M. Brown, and Dr. M. H. Elliot-Smith spoke in favour of the idea. Dr. A. M. Davidson insisted that all sections of the profession should be included in the convention. Dr. O. J. Ellis thought that the convention should be representative of the whole of Australia, and he therefore moved as an amendment:

> That all schemes, including a concrete scheme based on the Federal Council's scheme, be submitted to the Branches and through them to the local associations, following on which a convention representative of all Branches of the profession throughout Australia be convened to come to finality.

The amendment was seconded by Dr. H. M. Rennie. Dr. M. H. Elliot-Smith opposed the amendment as being unwieldy and impossible. He thought that the New South Wales Branch should seize the opportunity given to it to give a lead in this matter. His association thought that no scheme should receive the final approval of any authority until it had been referred back to local associations for their consideration. It also had to be remembered that the views of a convention which was not thoroughly representative might not represent the views of members. The amendment, on being put to the meeting, was lost.

With the permission of the meeting Dr. A. L. Caselberg re-worded his motion. It was then carried in the following form:

> That a convention consisting of delegates from the local associations and all sections of the profession and the Council of the British Medical Association be called immediately to formulate the best scheme for a national medical service and that such scheme shall be presented by the Council of the New South Wales Branch to the Federal Council as the opinion of this Branch.

Illness of the Medical Secretary.

On the motion of Dr. A. L. Caselberg, seconded by Dr. O. J. Ellis, it was resolved that a letter of sympathy be written to Dr. J. G. Hunter in his illness, expressing the hope that he would make a speedy recovery.

Vote of Thanks.

On the motion of Dr. O. J. Ellis, a vote of thanks was accorded to the President for having presided at the meeting.

NOTICE.

CLINICAL MEETINGS IN MELBOURNE.

1. A CLINICAL meeting of the hospital staff will be held in the Convalescent Officers' Mess at 115 (Heidelberg) Military Hospital at 8 p.m. on the first and third Tuesdays of each month.

2. A clinical meeting of the honorary medical staff will be held on the third Wednesday of each month in the lecture theatre, pathology department, Saint Vincent's Hospital, Fitzroy, at which the principal speakers will be officers of the U.S.A.S.O.S.

All members of the British Medical Association are invited to attend both series of meetings and information concerning the programmes of the meetings may be obtained at the office of the Victorian Branch four days beforehand.

Public Health.

PARLIAMENTARY JOINT COMMITTEE ON SOCIAL SECURITY.

THE Parliamentary Joint Committee on Social Security was appointed "to inquire into and from time to time report upon ways and means of improving social and living conditions of the people of Australia and of rectifying anomalies in existing legislation". The personnel of the committee is as follows: Mr. H. C. Barnard (Chairman), Senator Cooper (Deputy Chairman), Senator Arnold, Mr. Maurice Blackburn, Colonel R. S. Ryan and the Honourable J. A. Perkins.

An account of evidence already given before the committee has been published in previous issues.

SIR JAMES BARRETT, Honorary Secretary of the Victorian Bush Nursing Association, being sworn, informed the committee that he was Honorary Secretary of the Victorian Bush Nursing Association and had worked on the staffs of hospitals in Britain, Egypt and Australia. During the 1914-1918 war he had been associated with the Australian Army Medical Corps and the Royal Army Medical Corps in Egypt. He had also visited hospitals and medical schools in Great Britain and the Dominions, Belgium, Austria, Germany and the United States of America.

The Victorian Bush Nursing Association commenced its activities in 1910 by placing nurses in remote areas against universal opposition. It now had the whole of the country people and most of the medical profession behind it, and two days previously he had opened the sixty-third bush nursing hospital and five more hospitals would be opened if nurses could be obtained.

Country people wanted doctors, nurses and hospitals near their homes at rates within their means. The system was a cooperative one covering thousands of people and the Association neither asked for nor desired government support, except that already given in the form of railway passes for nurses to the value of some £300 *per annum*; in fact the main wish of the Association was that outside agencies would not interfere with its activities. The demand of country people for facilities close at hand over-rode everything else, and in general the whole of the medical service in bush nursing hospitals was conducted locally.

The fees in those hospitals were the lowest in the world, as was the maternal death rate which was less than two per thousand confinements, while the infantile death rate was half that of the State rate.

The Association over the years had turned from bush nursing centres to bush nursing hospitals which now had approximately 700 beds costing approximately £150,000 or £250 per bed in contrast with other hospitals costing £1,600 to £2,000 per bed. The result was that country people obtained hospital accommodation at low rates not available in the cities.

The Bush Nursing Associations in New South Wales (where hospital provision was limited to two beds), Queensland and Tasmania accepted government money and consequently government control, and had not progressed as in Victoria, where the Association had been able to offer its facilities to the State Emergency Services and in an emergency could provide beds for 1,500 patients. In all the newer bush nursing hospitals separate quarters for nurses had been constructed, and as the Association paid its nurses well, it obtained good ones. At present there was a shortage of forty in the nursing complement and the position would probably not be righted until the war ended, as some nurses were working in munition factories and others in shops, and when attempts were made to obtain them for duty in the country they produced an epidemic of sick mothers or medical certificates testifying that the condition of their feet would not permit their employment as nurses. Actually a nurse employed in Melbourne at £5 per week was not so well off as in a bush nursing hospital where she would receive excellent accommodation, free laundry, one month's annual holiday and would be insured against illness and accident.

A married man paid 30s. *per annum* membership fee to a bush nursing hospital and in return was entitled to hospital accommodation for himself and his family at £2 10s. per week.

At Korumburra there was in addition a system of hospital insurance, contributors to which could receive sixteen guineas worth of hospital accommodation in any year.

Replying to Mr. Barnard, Sir James said that the general desire of 63 bush nursing hospitals and 16 centres was to be left alone and he could see no reason why the system should be fitted into any national scheme. Four or five years ago it had been suggested that bush nursing hospitals should come under the control of the Charities Board of Victoria and the largest deputation he had ever seen had waited on the Premier and opposed the proposal.

He could not express any opinion on the working of the system of medical services under the *Social Security Act* in New Zealand, but he could be quite certain that it would be very expensive. Some years ago New Zealand had imposed taxes for the maintenance of hospitals, and with the establishment of a government bureaucracy local interest disappeared and voluntary contributions ceased.

The bush nursing system could be extended throughout the Commonwealth and would have been if other States had not accepted government money which resulted in the population sitting back and not helping itself.

He considered that the whole of the present hospital system was wrong. A few big central hospitals were needed in the city and the country, but the main need was for small well-equipped hospitals providing accommodation at moderate cost.

In Canada there were medical administrators in charge of hospitals who knew more about hospital management than anyone, and they had told him that the optimum size for a hospital was 300 beds, while an American surgeon put the figure at 250. Huge hospitals, such as one in New York with 4,000 beds, were top-heavy, and small economically conducted hospitals with the preservation of the "personal touch" were the solution. But for the fact that the use of trust funds of the Bush Nursing Association was restricted to the country, there would have been bush nursing hospitals in the Melbourne suburbs.

It would not be practicable under any system, except at enormous expense, to have such facilities as deep X-ray equipment or pathological blocks in every hospital, but in fact that was not necessary. At Korumburra, for example, it had been found that less than 4% of patients required to be moved elsewhere for special investigation or treatment.

The committee of one bush nursing hospital had reported that the committee of a public hospital 25 miles away had complained that but for the existence of the bush nursing hospital the public hospital would have been able to obtain more patients and charge them higher fees. Last year the total credit balances of bush nursing hospitals in Victoria amounted to £9,750. He thought that group practice would work in larger towns, but it was not practicable in small centres.

In reply to Mr. Perkins, Sir James said that nurses carried out domiciliary nursing from bush nursing centres, but not from hospitals.

The "high priest" of preventive medicine was the general practitioner who knew and dealt with families. The idea of doctors working at centres cut across the roots of satisfactory medical service which should be provided in the home or the hospital.

The largest town with a bush nursing hospital was Kerang, and in all bush nursing hospitals local chemists provided the necessary pharmaceutical services.

Replying to Senator Arnold, Sir James reiterated that bush nursing hospitals should be omitted from any plan involving the taking over of hospitals by the Government. A tax for hospital maintenance would be disastrous and the Bush Nursing Association desired neither government subsidies nor government control. At present the Association held trust funds amounting to £80,000 to £90,000, and the Lady Dudley Fund stood at about £16,000, and it financed its own activities.

A non-contributor could enter a bush nursing hospital at full rates, usually about £5 5s. per week, while provision of medical attention was a matter between the patient and his doctor. They knew each other and arranged fees between themselves.

Bush nursing hospitals accepted all emergency cases without question, and if a patient was too poor to pay hospital fees and if a separate fund to pay for him did not exist, he was later transferred to a public hospital. Such funds under the control of trustees had been established in several places, notably at Korumburra, and by their aid the poor were catered for in their own districts. Local councils had helped such schemes in some cases, and he would not object to the Government making contributions to those separate funds, as they were not connected with the Bush Nursing Association.

Nurses employed by the Bush Nursing Association examined children on behalf of the Education Department.

Replying to Senator Cooper, Sir James said he could not estimate the number of bush nursing hospitals which might

be needed as each district created its own demand for one to be established. He had always opposed the construction of a hospital until certain that the district was behind it, and the Edward Wilson Trust forbade the use of its money unless self-help was demonstrated. The original forty-four nursing centres had been reduced to sixteen owing to conversion of centres to hospitals. Country people wanted doctors, nurses and hospitals, and all nurses employed were double-certificated and treated only emergencies without medical advice.

Centres only, not hospitals, received aid from the Government to the extent of £340 *per annum* in the form of rail passes *plus* £119 for work done for the Education Department. Moneys received from the King George V Jubilee Fund had been used for maternal welfare by improvement of operating theatres *et cetera*.

The only standards imposed on bush nursing hospitals were those of the *Health Act* applicable to private hospitals.

At the conclusion of Sir James Barrett's evidence the Chairman accepted his invitation to the committee to inspect the bush nursing hospital at Fern Tree Gully and said that he had no idea that the Association had done so much in Victoria.

MR. W. HARTLEY WELLS, furniture warehouseman and President of the Korumburra Bush Nursing Hospital, being sworn, said that about fifty years ago a site had been allotted at Korumburra for a cottage hospital and £200 had been collected and remained in the bank until it amounted to £400. Later a committee had been formed, and by holding sports gatherings brought the amount up to £3,000, and in 1931 a bush nursing hospital costing £4,500 was opened. Today the assets of the hospital amounted to £10,000 to £12,000, with a daily average of patients of 13. Triple certificated nurses were employed and one of the sisters visited the homes if necessary. All funds for the hospital were raised locally and they included a few donations and some bequests.

The Bush Nursing Association was owed £500 and the Central Council had provided about £800 for equipment. The hospital was quite capable of providing for the sick of the district and no one was turned away.

During the depression it had been decided to establish a hospital insurance scheme and that had been done in 1934. Groups had been formed among coalminers, railway employees, farmers and townspeople and the annual revenue of £329 in 1934 had increased to £619 in 1941, the total revenue for eight years being £4,225.

The contribution was sixpence per week per family and the 500 members represented 3,000 people in a population of 8,000.

Claims paid were £236 in the year of establishment and £382 in 1941. Expenses for eight years were £206 and a surplus of £750 had been paid to the hospital. Indigent people were provided for by a separate fund under separate control and the committee of that fund paid the hospital about 75% of fees incurred. The insurance scheme paid £4 4s. for four weeks in any one year on behalf of any member or his dependants admitted to the hospital, and after four weeks a member could remain in the hospital indefinitely at the reduced rate of £3 3s. per week. The two doctors in the town attended the indigent without reward.

MAJOR-GENERAL SAMUEL ROY BURSTON, Director-General of Army Medical Services and Chairman of the Central Medical Coordination Committee, being sworn, stated that he had not had an opportunity to give the matter sufficient consideration; but, broadly, his conception of the medical, hospital and health services required by the people of Australia was a service that would provide every class of the population with adequate and efficient medical attention, full access to all modern facilities in diagnosis and treatment of disease, full provision for expert specialists' advice and treatment where necessary, and adequate and up-to-date hospitalization. The service should also include all necessary measures to educate the public in preventive measures and provide full facilities for such measures. He considered that a full service of the above nature should be available to every member of the community, irrespective of income, and should conform with the following broad principles: (i) That the scheme adopted should provide the public with a better medical service than it had at present. (ii) That the service should be acceptable to the medical profession and attractive enough to induce the best type of men to enter the service. (iii) That the scheme should be administered, not by a government department, but by some form of committee composed chiefly of medical practitioners of the highest standing, with possibly one or more laymen of proved administrative ability to advise them. To get efficiency, the one thing that must be avoided at all costs was anything approaching a bureaucracy. The service should be administered, not by a government department under a permanent head, but by a body of men of the highest possible standing in the profession. They should be put somewhat on the plane of judges in the legal profession. They should be adequately remunerated for their services, and should be of such standing that they would have no motive other than to give efficient service. In those circumstances, there would be a service in which efficiency and professional qualifications would be a prime consideration in any promotion in a professional capacity. There would be no question that because a man had been ten years in a certain grade he would be entitled to promotion to the position of a consultant. Promotion should be made purely on merit. The next broad principle to which the scheme should conform was: (iv) That the freedom of choice by the patient of his medical adviser should be preserved. Those who had done many years of practice realized that there was far more in looking after people than diagnosing their complaint and giving them treatment. The personal factor was of great importance. Those doctors who had been in practice for twenty years or more got to know the background of the patients and their families. The doctor was regarded as a friend. The other principles to which the scheme should conform were: (v) That the right of private practice should be preserved. (vi) That full opportunity for post-graduate study should be available to medical practitioners in the service.

He did not consider that any of the schemes suggested were entirely suitable for application in Australia. Each had its good points, but would need considerable modification before it could be effectively implemented in this country. If any scheme for a national medical service was contemplated, it would be obviously most unjust to bring such a scheme into force until the medical men on service, who comprised the majority of those who would be most affected by the scheme, had had ample opportunity to express their views, and also until they were in a position to be considered for appointments in such a national medical service. He, therefore, felt most strongly that a national medical service should not be introduced during the war.

He considered it important that all the health services mentioned should be included in any proposed scheme. Any of these services which would entail an added strain on the medical profession should not be implemented until after the war. His reason for making that statement was that at the present time, owing to the number of men on service, medical practitioners had had a great strain placed upon them, and he thought that if an increase of any of those services was brought into effect during the war, the added strain on the civil medical practitioners must adversely affect both their health and efficiency.

At present there was a disturbing increase of illness and deaths among civil medical practitioners. The chief reason was that they had had no opportunity to obtain rest or relaxation. When a civil medical practitioner was definitely in need of a spell, and could not obtain a *locum tenens*, Major-General Burston detailed a medical officer to do duty for him while he got a rest. Air Vice-Marshal Hurley was doing the same. It would be unwise at present to try to develop ancillary schemes to any great extent. That would do more harm than good, but all the plans should be got under way so that they may be put into effect as soon as possible. He did not feel competent to discuss the financial aspects at present, as he had not had the time or the opportunity to give the matter full consideration. Nor for the same reason did he feel able to give a considered opinion as to whether the scheme should be on a salaried or a capitation basis, or whether the finance should be met by a form of insurance affecting only those insured or by taxation spread over the whole community; except that he was strongly of the opinion that, if the latter course were adopted, all persons benefiting by the scheme should share in the cost of maintenance.

For the efficient administration of a national medical service, he considered it essential that the administration should be in the hands of the medical profession, assisted possibly by a limited number of laymen of sound business and administrative experience, and, if thought necessary, a representative of the Government. That committee could function in the same way as the present Central Medical Coordination Committee through State committees similarly constituted. At the present time the Central Medical Coordination Committee existed for the control of the civil medical service and the coordination of the civil and military needs both in personnel and equipment. The machinery which now functioned could, to some extent, be taken over as the nucleus of the machinery for administration of any new scheme brought into force.

Replying to Colonel Ryan, General Burston agreed that whatever scheme was adopted should be worked out now, rather than left until the end of the war.

He recognized the necessity for everybody concerned to be fully consulted, particularly those doctors who were absent on active service, and although it would not be possible to obtain a 100% reflection of the opinion of absent doctors, he thought a general idea of the reaction of men on service to any scheme could be ascertained and then comments and suggestions obtained by circularizing them. If the committee had a definite scheme in mind arrangements could be made for circulars to be distributed through army channels. It was of such importance that the scheme should work smoothly and well that it would be worth while taking the necessary time to get the full cooperation of the profession. He thought each State had somewhat different views on the matter. He did not think the serving men would speak with one voice, except that they would require an equal opportunity with others to take part in the preparation of any scheme to be adopted. A salaried scheme would have certain advantages, such as superannuation, which would give security to medical men in their old age, but he thought the average young man in the profession started off with ambition and hoped to get to the top in a few years. Under a salaried scheme there would not be the same incentive as now existed for a man to reach the top of his profession. The lazy man would say: "I am certain of my salary and as long as I do my job I am right." Most frequently, medical partnerships were not satisfactory, because although the partners might have an equal knowledge of their job, one man had a stronger appeal to the public, with the result that while his work increased, that of the others decreased. That applied to some degree to the panel system, but there the doctor with the larger practice got greater rewards for his efforts. Some doctors were capable of doing more work than others, and one doctor looking after 50% more patients than another should not be expected to do it for the same remuneration as that received by the other man. Under a salaried system for general practice it would be necessary to try to equalize the number of patients for which each man was responsible. The only way to do that would be to force patients to visit doctors whom they did not wish to patronize. The doctor who had a scientific job had a full-time occupation and he might consider his salary adequate, but that did not apply to the general practitioners. In the Indian Medical Service the doctor had to attend to a very large number of patients, but there the personal factor did not count so much.

At present there were two classes in the community who, as far as investigation and treatment of their complaint went, were "on the box seat"; they were the poorer class and the well-to-do class. The poorer people had the facilities of big public hospitals, where they got a better "spin" than the average citizen, if they had a complaint that required special treatment or a special type of diagnosis. The cost was not taken into consideration. The well-to-do class got about as good a service as the poorer class, but the unfortunate people on an income which prevented them from getting free treatment in public hospitals and earning up to say £600 or £700 a year, were in a different position if they had an illness or disease which required special investigation and treatment. All the pathological and biological investigations were expensive for them. In the past the medical profession had "carried the baby" for many people of the poorer class, but people of independence bore the expense of medical attention and often thereby ran themselves into debt. Under a scheme such as he visualized, in which the income limit would be abolished, he thought the position would be met. People in the middle class category would go into public hospitals and get the full benefit.

Replying to Senator Cooper, General Burston said he did not apprehend any difficulty in regard to a national medical service provided it was separated from the Public Service. He had a business adviser in his directorate who was an accountant of high standing and most useful. He was sure that a man of that type would be of great value to a commission controlling a scheme such as that contemplated. It would be necessary to have men of the highest standing in each zone or State, who would be looked on as consultants to give advice with regard to local promotions and would submit recommendations, the matter being finally decided by the central body. The local bodies would have to be composed of doctors of the senior consultant type, who might be paid on a part-time basis. The important thing was to get men who were above anything except a desire for efficiency, who knew all the doctors fairly well and who took an interest in their progress after qualification. That type of man would, he thought, be acceptable to the medical profession as a whole. A salaried service would be satisfactory in certain country districts. It was necessary to give doctors an opportunity for promotion and that might mean promotion to another district. In many country districts the man or men practising had been there all their lives, and if a country town frequently had to change its medical adviser the people would consider they were getting a bad "spin". He admitted there were many arguments for and against each type of service, but he did not think a complete salaried service would be wise. The fee-for-service system would be more equitable than a salaried service and would meet the difficulty because the more popular man who did more work than his fellows would receive more remuneration. The average medical man worked hard and saved up money to enable him to obtain post-graduate training abroad. In peace time there was no real difficulty in obtaining a *locum tenens*. The chief objection he had to a salaried system was that it was a leveller. It was difficult to see how a salaried service was to be entirely avoided, but he thought it should be limited to such matters as public health and hospitals and to country districts which could not support a medical man. The remuneration of specialists in hospitals was apparently working satisfactorily in Queensland. The honorary system placed a great burden on the men who took those positions. He had been on the honorary medical staff of the Royal Adelaide Hospital since 1914, and the hours he had given to that work constituted probably half his working time. The system had worked well, and in most cases the best men available had been appointed to the staffs of the hospitals, but he admitted that the middle class to which he had referred was not well served under that system.

A periodical health survey of the civil community would be extremely useful in the control and prevention of such diseases as tuberculosis, as when there was an early discovery of the disease lives could often be saved, but nothing short of a thorough medical examination would be of much value and that would entail a great many man-hours and would be costly. The most useful thing to do would be to examine people for such diseases as tuberculosis and it would only be necessary to do that at certain ages. One commission would have to be responsible for the supervision of both the hospitals and the medical profession and the work would have to be coordinated at the top.

In reply to Senator Arnold, General Burston said he was rather frightened of a salaried service, because he feared that it would destroy the incentive of the enthusiastic young doctor to rise quickly to the top of his profession. It might be possible to adopt a system whereby the medical profession could be placed on an adequate salary, with provision for post-graduate study, superannuation, holidays *et cetera*, but there should be every incentive for a man to give of his best and he should know that he would be able to progress in his profession. He thought the service could be administered in a way that would give protection to the efficient man, but it would be necessary to be quite certain that an outstanding man could get promotion quickly. It was most important that men on the professional side should receive higher pay than those on the administrative side, as the professional men in control would have to keep an eye constantly on the calibre of the men in the service and they would have to do it on a carefully considered basis. The success of any scheme would be dependent on the standard of the professional service. The average medical man had not had great difficulty in establishing himself in the lodge type of practice, either in a suburb or in the country. He had to be prepared to put down some capital, but if he was a good type of man he could usually obtain financial accommodation, and if he was content with that type of practice he probably, in a few years, reached a fairly sound position. The man who had ambition to get into the top consultant class should do a general lodge practice for five years and then undertake post-graduate work. He then had to spend a good many years on a small income, but as he succeeded at the job he gradually obtained a consultant following and eventually reached a fairly good position. He did not consider that many good men were prevented from becoming specialists because of financial handicaps. If a doctor showed promise, the senior men put work in his way and encouraged him. The more brilliant young men should have opportunities to go on to specialist studies, but the chances of obtaining post-graduate study now were not great.

At present Australia had as high a standard of medical service as any other country, and a better service than that of many countries. The standard of medical knowledge and the proficiency of the ordinary practitioner in Australia were extremely high. Whether a medical man was overworked now depended largely on himself. He attached great impor-

tance to a free choice of doctors and to the relationship between the doctor and the patient. He had always regarded the family as an important factor in the community and the family doctor had a tremendous influence for good. He helped and advised families in all kinds of ways and it was extraordinary how families attached themselves to doctors. He thought it would be a retrograde step to abolish that principle, and considered it could be preserved to a great degree in a national medical service. There would be the difficulty, however, of doctors being transferred from one locality to another. Whether the advantage to the doctor would outweigh the disadvantage to the patient was difficult to say. He believed that the people generally would get straight-out medical attention, but they would lose something which had been of a very great advantage to them in the past. The psychological effect of the family doctor played a big part in the cure of a patient, and the knowledge of the family environment was a great help to the doctor. In England it was the custom for three or four men to carry on a panel practice on a sort of clinic and roster basis, but he thought it was generally admitted that that lowered the medical standard in general practice.

In reply to Mr. Perkins, General Burston said that the professional and ethical standards of the medical profession in Australia compared favourably with those in other parts of the world, and the Australian practitioner had high ideals of his duty to his patients. He was astounded at the trouble taken by doctors with their lodge patients, which showed the keenness of the men in their jobs. He thought Australian medical schools held their own with any of the world. If a national medical service was made reasonably attractive he thought that many good men, whose fathers and even grandfathers had been doctors before them, would desire to continue in the profession, and believed that they would still have an ambition to rise to the top. Doctors had a more or less recognized standard of fees applicable to general practice, but in other cases the personal factor was considered. A man might reasonably be forced to put up his fees, otherwise he would be inundated with work; but on the whole he regarded the fees charged as reasonable. Under a scheme of compulsory medical examination, children and adolescents were the most important classes to be considered, and then the late middle-age group. Periodical examinations during childhood and adolescence and during adult life would be beneficial. The standard of hospitals in Australia compared with those overseas was high.

Replying to Mr. Barnard, General Burston said that he failed to see that the problem of providing an improved medical service could be solved now, without introducing something in the nature of a complete national scheme. At present the provision of proper attention for the civil population constituted a very difficult problem. That service was supervised by the State coordination committees under a central committee and it was necessary to see that no locality in the Commonwealth was left without adequate medical attention. That coordination was working extremely well, and the medical attention for the civil population was being looked after as well as it could be. The machinery by which the present scheme was operated was very much the same as would be necessary to provide a national health service. The Commonwealth Government formed a central coordination committee, under the Prime Minister's Department, as an emergency defence measure. The committee was executive and was charged with the control of the whole of the medical personnel of the Commonwealth. A Director-General of Emergency Medical Services had been appointed, and every medical practitioner under 60 years of age was compulsorily enrolled. State executive officers and State coordination committees were set up in the same way as the central body, and through that chain the whole of the medical practitioners in the Commonwealth were controlled. The central body also coordinated the supply of medical personnel to the army, not overlooking civil needs. Before any doctor could be enlisted in the army, a State coordination committee reported to the central committee that that man was available, and nobody was taken out of civil practice unless the State committee considered that he could be spared. Another function of the committee was to control and coordinate the medical equipment of the Commonwealth for both defence and civil requirements, and the Medical Equipment Control Committee had very large powers. It did practically all the purchasing outside Australia, and its job was to see that medical equipment, including drugs and all stocks that could be manufactured in the Commonwealth, were produced here. The Coordination Committee also dealt with nurses, dentists and pharmacists and in each State there was a State executive officer. The scheme was working smoothly and he thought the machinery might be adapted for a Commonwealth medical service in peace time, but a survey of hospitals and medical services should be undertaken before any complete scheme was put into operation. That would have to be done by a body on which there was representation of the medical profession and also lay personnel thoroughly familiar with hospital administration. It would also be necessary to have somebody like the Director-General of Health, whose job had been to keep close watch on health matters.

An X-ray examination of the members of the Service for the detection of tuberculosis had been of great value, and some such examination should be continued after the war. The number of tuberculosis cases in the army which had slipped through was extremely small, and the chances were that those cases would have been missed under any system. On the civilian side, chests should be examined of the adolescent and the young adult up to the age of 25 or 30 years, and if the examination showed any sign of active tuberculosis, that person should be looked after properly. The examination should be more or less compulsory for the protection of both the individual and the community. He did not think X-ray examinations of the chest of civilians for tuberculosis could be undertaken during the war and the number of examinations in the army was limited at present to the quotas as they were called up. It would interfere greatly with all the essential services if such a scheme were inaugurated now, and if it was to be of any use it would be necessary to include people up to the age of 25 or 30 years. The extra strain that that would impose on the profession would make the scheme impracticable.

For doctors back from the war, post-graduate courses should be provided. That was done after the last war, when medical officers were given an opportunity to go to London and were given special leave for post-graduate work, and every facility was given to them to attend such hospitals or clinics as they desired to visit.

General Burston informed Colonel Ryan that the majority of doctors believed that a salaried scheme would destroy the initiative of the younger members of the profession. Under the present system a good man might rise to the top in his early forties, but under a salaried system it would be difficult to justify the acceleration of a man's promotion at that rate. A complete salaried service would lower the standard of the profession.

General Burston informed Senator Arnold that the cost of educating a young man to be a doctor was considerable. The university fees amounted to £60 or £70 a year and all kinds of equipment had to be acquired. The average age at which a student set out was about 18 years, and normally a student had to be maintained for about six years. If he was to be successful he had to do a resident job in a hospital for two years, and then, if possible, he went abroad for further training. In South Australia, government bursaries were given to men who showed ability and could not afford a university course, and provision should be made in any scheme whereby persons showing aptitude for medicine should have the necessary facilities for training.

General Burston informed Senator Cooper that doctors of the consultant class should congregate in cities, where the teaching schools were. He thought that under a salaried scheme country people would have a chance of getting a better specialist service, as under such a scheme there could be zones with consultant clinics in each zone with specialists available for consultant work to all the doctors in that area. That would only be effective in centres having a reasonably large hospital to which the doctors could be attached, as were the consultants in the big cities, and under any scheme doctors who had become well known would decide to try their luck as private consultants. That would give the public the benefit of the services of private men and that opportunity should always be present, even under a salaried scheme.

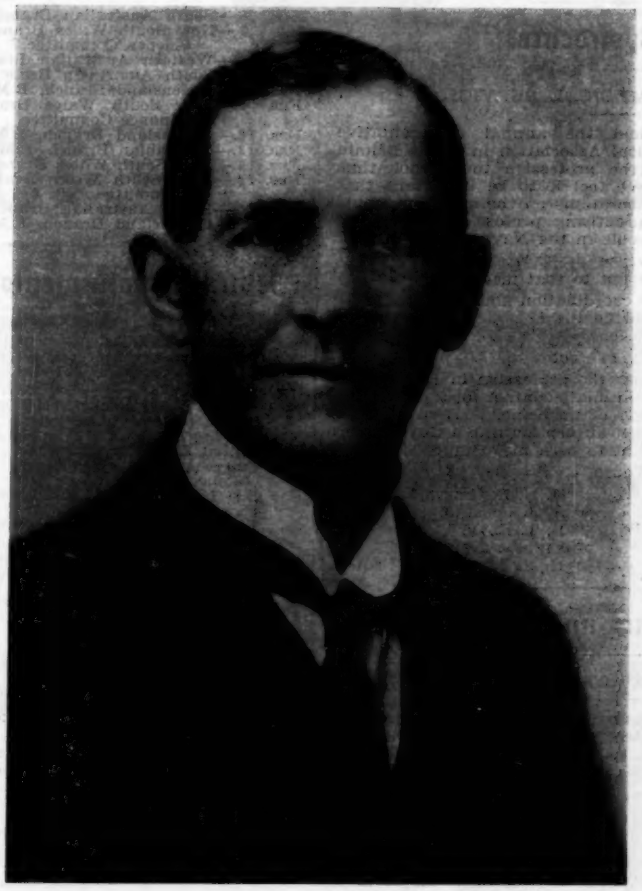
Obituary.

GEORGE HENRY ABBOTT.

FEW medical men have more justly earned the respect and confidence of their colleagues than Dr. George Henry Abbott, whose death was recently recorded in this journal. To the younger graduates of today he was but little known, but those who joined the ranks of medicine in New South Wales twenty or twenty-five years ago knew him as a surgeon of the front rank, slow but sure, and a man of sterling

character and worth in whom patience and sympathy with suffering humanity were combined in an extraordinary degree.

George Abbott was born on August 20, 1867. He was the son of Joseph Abbott, who was a partner in the original firm of Mort and Company and for some years a member of the Legislative Assembly of New South Wales, representing the electorate of Newtown. The boy at the age of seven years attended a school conducted by Mrs. Jane Cheers and situated opposite the site on which Prince Alfred Hospital was later built. When Mrs. Cheers retired he went to Mr. Sampson's Academy near the home built by his father on the corner of Carillon Avenue and Prince's Highway, since occupied by five medical practitioners. In 1881 he went to Newington College where he had a brilliant career, becoming *dux* of the school and winning the Schofield Scholarship. As a matter of fact he was the eldest of five brothers who went to Newington College, the name of Abbott being on the school roll for a period of twenty years. Just before he left Newington College, George Abbott passed the Senior Public Examination in nine subjects, gaining several first class passes and winning the University medal in geology. In those days the *literæ humaniores* were of more account in the education of a professional man than they are today and so Abbott became an undergraduate in the faculty of arts at the University of Sydney. In his matriculation examination he won the Barker Scholarship, Number 2, for mathematics and gained first class honours in mathematics and second class honours in classics and chemistry. He seems to have had an aptitude for physical science — in 1886 he won the Deas-Thomson Scholarship in that subject. He graduated as Bachelor of Arts with first class honours in mathematics. Turning his attention to medicine, Abbott was brilliantly successful. Scholarships and prizes were not very numerous, but he annexed most of them. He won the Renwick Scholarship in the first professional examination and the John Harris Scholarship for General Proficiency in the second. He won Dr. Milford's prize for surgery, Dr. Wilkinson's prize for pathology and Dr. Dixon's prize for *materia medica*. He gained second class honours at graduation in 1891. During his undergraduate days he was President of the Sydney University Medical Society.



Having gained the "coveted M.B.", Abbott became resident medical officer at Prince Alfred Hospital which had not at that time received the title of "Royal". Here he must have given evidence of a capacity for surgery, for after having spent a few years in general practice at Petersham, a suburb of Sydney, he was appointed honorary assistant surgeon to that hospital. This was in 1899. In his work as a general practitioner Abbott displayed the qualities that were so prominent throughout his whole professional life. As one of his former colleagues has written of him: "He began general practice at Petersham, where he soon became known for his great professional ability, his kindness of heart, his unlimited patience with the sick and his inexhaustible fund of sympathy." Students allotted to him in his hospital work at first rather dreaded what appeared to them the over-long sessions in the operating theatre—and students can be intolerant when they do not understand. Gradually, however, it began to dawn on them that the meticulously accurate and gentle treatment of the body tissues produced results not at the disposal of every surgeon, particularly of those who worked with one eye on the clock. After his appointment as honorary surgeon in 1908 and as lecturer in clinical surgery in 1911, Abbott had a great deal to do with the teaching of students, and it is illuminating to read the references to him in the annual year book produced by each successive batch of students before their graduation. Invariably they write of him with affection, often calling him "Dad". We read: "Technique, asepsis and delicate touch are strong points with him." Again: "Outstanding in delicacy of touch and painstaking thoroughness." And: "The cunning of his skill and the remarkably good results of his handiwork led us to admire his methods more and more." Medical students, it is commonly agreed, are among the most discerning and candid of critics. In 1927 Abbott retired from the active staff of the Royal Prince Alfred Hospital and became honorary consultant surgeon; in the following year he resigned his lectureship in clinical surgery.

George Abbott took an active part in the affairs of the British Medical Association. He was, we understand, the first graduate in medicine of the University of Sydney to become a member of the New South Wales Branch. He served the Branch as honorary secretary, honorary treasurer, vice-president and president—he was president in 1908. He was for some years a member of the Federal Committee. When it was decided that the third session of the Australasian Medical Congress (British Medical Association) was to be held in Sydney, Abbott was chosen to be president. This was one of the largest medical gatherings that had been held in Australia. Dr. T. W. Lipscomb and the late Arthur Aubrey Palmer were joint honorary secretaries and the fifteen sections were the centres of long and important discussions. The gathering from every point of view was a success and all who took part agreed that the success was in no small measure due to the happy choice that had been made of president. It was typical of him that in his address to congress Abbott bade busy practitioners not to be weary in well-doing and that he quoted the words of Sir Thomas Browne: "Let not disappointment cause despondency, nor difficulty despair"—a message that can be well applied to the problems of today.

George Abbott was one of the Foundation Fellows of the Royal Australasian College of Surgeons and he held other honourable positions in the community. He was a member of the Senate of the University of Sydney, a member and later chairman of the Council of the Women's College. Three times he was president of the Royal Australian Historical Society. He was a member of the Royal Empire Society, of the Royal Society of Saint George, of the Royal Numismatic Society, of London, and of the Australian Numismatic Society, which he helped to found. He was an authority on ancient coins and had a large collection. He

also collected pictures of Australian birds, rare books and other art treasures. He was a director of the Australian Mutual Provident Society.

Of George Henry Abbott it may be said that he lived a full and useful life and that the place of his sojourn was the better for his having lived.

PAUL LOUIS FLORANCE.

We regret to announce the death of Dr. Paul Louis Florance, which occurred on January 8, 1943, at Cootamundra, New South Wales.

Correspondence.

A SALARIED MEDICAL SERVICE.

SIR: On September 9 last the annual representative meeting of the British Medical Association in Great Britain considered the attitude of the profession to a whole-time salaried medical service. We feel it to be important that the result of this body's deliberations on the question should be emphasized before the practising profession throughout Australia and as far as possible in the Navy, Army and Air Force.

The following motion was put to that meeting:

> That the basis for the coordination and integration of health services should be the establishment of a whole-time salaried service.

This motion was defeated by 177 votes to 20.

This signifies, in effect, that the profession in Britain, the members of which have had intimate contact for a generation with governmental regulation of medicine, is resolved by a majority of nine to one against absorption into a Government medical service. We feel that to be a most impressive fact.

Yours, etc.,

H. R. R. GRIEVE,
A. J. COLLINS,
B. T. EDYE,
LINDSAY DEY,
K. S. MACARTHUR BROWN.

Naval, Military and Air Force.

CASUALTIES.

ACCORDING to the casualty list received on January 13, 1943, Major G. F. S. Davies, A.A.M.C., who was previously reported missing, is now reported to be a prisoner of war.

According to the casualty list received on January 14, 1943, the undermentioned, who were previously reported missing, are now reported to be prisoners of war: Captain A. K. Barrett, A.A.M.C., of Rose Bay; Lieutenant-Colonel W. A. Bye, A.A.M.C., of Sydney; Major R. Dick, A.A.M.C., of Balgowlah; Major C. R. Furner, A.A.M.C., of Mayfield; Captain A. R. Hazelton, A.A.M.C., of Artarmon; Major E. A. Marsden, A.A.M.C., of Camperdown; Captain P. T. Millard, A.A.M.C., of Lindfield; Captain R. G. V. Parker, A.A.M.C., of Rose Bay; Major D. A. Procter, A.A.M.C., of Mosman; Captain A. F. Smith, A.A.M.C., of Neutral Bay; Captain R. G. Wright, A.A.M.C., of Wagga; Captain C. P. Juttner, A.A.M.C., of Woodside, South Australia.

DECORATIONS.

We have been notified by the Director of Medical Services of the Royal Australian Air Force that Flight Lieutenant A. C. Blumer, of the Royal Australian Air Force Medical Service, has been mentioned in dispatches.

Medical Appointments.

Dr. William Alexander Sloss has been appointed a member of the Charities Board of Victoria, pursuant to the provisions of the *Hospitals and Charities Acts* of Victoria.

Books Received.

"Medicine: Essentials for Practitioners and Students", by G. E. Beaumont, M.A., M.D., F.R.C.P., D.P.H.; Fourth Edition; 1942. London: J. and A. Churchill. 9¼" × 6", pp. 818, with 71 illustrations. Price: 28s.

"A History of Tropical Medicine", by H. Harold Scott, C.M.G., M.D., F.R.C.P., D.P.H., D.T.M. and H., F.R.S.E.; Volume I and Volume II. London: Edward Arnold and Company. 9" × 6", pp. 1942, with illustrations. Price: 63s. net.

Diary for the Month.

JAN. 28.—South Australian Branch, B.M.A.: Branch.
FEB. 2.—New South Wales Branch, B.M.A.: Organization and Science Committee.
FEB. 3.—Western Australian Branch, B.M.A.: Council.
FEB. 4.—South Australian Branch, B.M.A.: Council.
FEB. 5.—Queensland Branch, B.M.A.: Branch.
FEB. 9.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
FEB. 12.—Queensland Branch, B.M.A.: Council.
FEB. 13.—Tasmanian Branch, B.M.A.: Annual Meeting.
FEB. 16.—New South Wales Branch, B.M.A.: Ethics Committee.
FEB. 23.—New South Wales Branch, B.M.A.: Medical Politics Committee.
FEB. 25.—South Australian Branch, B.M.A.: Branch.
FEB. 26.—Queensland Branch, B.M.A.: Council.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

Editorial Notices.

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